Assembly Bill No. 78

CHAPTER 525

An act to amend Sections 1618.5 and 4382 of the Business and Professions Code, to amend Sections 43.98, 56.17, 3296, of the Civil Code, to amend Sections 10821, 13408.5 of the Corporations Code, to amend Sections 1322, 6253.4, 6254.5, 11552, 13975, 21661, 31696.1, 37615.1, and to add Section 13975.2 to, the Government Code, to amend Sections 1317.2a, 1317.6, 1342, 1342.5, 1343, 1344, 1345, 1346, 1346.4, 1346.5, 1347, 1348, 1349, 1349.2, 1351, 1351.1, 1351.2, 1352, 1352.1, 1353, 1354, 1355, 1356, 1356.1, 1357.03, 1357.09, 1357.10, 1357.11, 1357.15, 1357.16, 1357.17, 1357.53, 1357.54, 1358, 1358.1, 1358.2, 1358.4, 1358.6, 1358.9, 1358.10, 1358.11, 1358.12, 1358.14, 1358.15, 1358.16, 1358.18, 1358.19, 1358.21, 1359, 1360.1, 1361, 1363, 1364, 1365, 1365.5, 1366.4, 1367, 1367.02, 1367.3, 1367.35, 1367.695, 1367.10, 1367.15, 1367.24, 1368.02, 1370, 1371.4, 1372, 1373, 1373.95, 1374.9, 1374.26, 1374.27, 1374.28, 1374.60, 1374.64, 1374.66, 1374.67, 1374.68, 1374.69, 1374.71, 1375.1, 1376, 1377, 1380, 1380.1, 1380.3, 1381, 1382, 1384, 1385, 1386, 1387, 1388, 1389, 1389.1, 1389.2, 1391, 1392, 1393, 1393.5, 1393.6, 1394, 1394.1, 1394.3, 1394.5, 1394.7, 1394.8, 1395.5, 1396, 1397, 1397.5, 1397.6, 1398, 1399, 1399.1, 1399.70, 1399.71, 1399.72, 1399.73, 1399.74, 1399.75, 11758.47, 32121, 34943, 102910, 127580, and 128725 of, to add Sections 1341.1, 1341.2, 1341.3, 1341.4, 1341.5, 1341.6, 1341.7, 1341.8, 1341.9, 1341.10, 1341.11, 1341.12, 1341.13, 1341.14, 1342.3, 1347.1, and 1391.5 to, and to repeal and add Section 1341 of, the Health and Safety Code, to amend Sections 740, 742.407, 791.02, 1068, 1068.1, 10123.35, 10140.1, 10196, 10270.98, 10704, 10733, 10734, 10810, 10820, 10856, 12693.36, 12693.365, 12693.37, and 12695.18 of, the Insurance Code, to amend Section 4600.5 of the Labor Code, to amend Section 830.3 of the Penal Code, to amend Section 5777, 9541, 14087.32, 14087.36, 14087.37, 14087.38, 14087.4, 14087.9705, 14088.19, 14089, 14089.4, 14139.13, 14251, 14308, 14456, 14457, 14459, 14460, 14482, 14499.71, 22005, and 22010 of the Welfare and Institutions Code, relating to health care.

[Approved by Governor September 27, 1999. Filed with Secretary of State September 28, 1999.]

LEGISLATIVE COUNSEL'S DIGEST

AB 78, Gallegos. Health care coverage: Department of Managed Health Care.

Existing law provides for the implementation of programs for the provision of managed health care by the Department of Corporations.

This bill would transfer responsibility for the implementation of those programs to the Department of Managed Care in the Business, Transportation, and Housing Agency, established pursuant to the bill, and would make conforming changes.

The bill would also establish in the Department of Managed Care an Advisory Committee on Managed Care to assist and advise the Director of the Department of Managed Care on various issues.

The bill would also establish in the department an Office of Patient Advocate, in order to provide educational material to plan enrollees and to render advice and assistance to enrollees.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares that it is in the public interest that the administration and enforcement of the Knox-Keene Health Care Service Plan Act of 1975, as amended, be undertaken by a department of state government devoted exclusively to the licensing and regulation of managed health care.

(b) Therefore, it is the intent of the Legislature to transfer the administration of the Knox-Keene Health Care Service Plan Act of 1975, as amended, from the Commissioner of Corporations of the Department of Corporations to the Director of the Department of Managed Care established in the Business, Transportation and Housing Agency.

SEC. 2. Section 1618.5 of the Business and Professions Code is amended to read:

1618.5. (a) The board shall provide to the Director of the Department of Managed Care a copy of any accusation filed with the Office of Administrative Hearings pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, when the accusation is filed, for a violation of this chapter relating to the quality of care of any dental provider of a health care service plan, as defined in Section 1345 of the Health and Safety Code. There shall be no liability on the part of, and no cause of action shall arise against, the State of California, the Board of Dental Examiners, the Department of Managed Care, the director of that department, or any officer, agent, employee, consultant, or contractor of the state or the board or the department for the release of any false or unauthorized information pursuant to this section, unless the release is made with knowledge and malice.

(b) The board and its executive officer and staff shall maintain the confidentiality of any nonpublic reports provided by the Director of the Department of Managed Care pursuant to subdivision (i) of Section 1380 of the Health and Safety Code.

SEC. 3. Section 4382 of the Business and Professions Code is amended to read:

4382. The board may audit persons for compliance with the limits established in paragraph (3) of subdivision (a) of Section 4380 except that in the case of a facility or pharmacy that predominately serves members of a prepaid group practice health care service plan, those audits may be undertaken solely by the Department of Managed Care pursuant to its authority to audit those plans.

SEC. 4. Section 43.98 of the Civil Code is amended to read:

43.98. (a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any consultant on account of any communication by that consultant to the Director of the Department of Managed Care or any other officer, employee, agent, contractor, or consultant of the Department of Managed Care, when that communication is for the purpose of determining whether health care services have been or are being arranged or provided in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and any regulation adopted thereunder and the consultant does all of the following:

(1) Acts without malice.

(2) Makes a reasonable effort to obtain the facts of the matter communicated.

(3) Acts with a reasonable belief that the communication is warranted by the facts actually known to the consultant after a reasonable effort to obtain the facts.

(4) Acts pursuant to a contract entered into on or after January 1, 1998, between the Commissioner of Corporations and a state licensing board or committee, including, but not limited to, the Medical Board of California, or pursuant to a contract entered into on or after January 1, 1998, with the Commissioner of Corporations pursuant to Section 1397.6 of the Health and Safety Code.

(5) Acts pursuant to a contract entered into on or after July 1, 2000, between the Director of the Department of Managed Care and a state licensing board or committee, including, but not limited to, the Medical Board of California, or pursuant to a contract entered into on or after July 1, 1999, with the Director of the Department of Managed Care pursuant to Section 1397.6 of the Health and Safety Code.

(b) The immunities afforded by this section shall not affect the availability of any other privilege or immunity which may be afforded under this part. Nothing in this section shall be construed to alter the laws regarding the confidentiality of medical records.

SEC. 5. Section 56.17 of the Civil Code is amended to read:

56.17. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by a health care service plan.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies

or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's ''written authorization,'' as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

SEC. 7. Section 3296 of the Civil Code is amended to read:

3296. (a) Whenever a judgment for punitive damages is entered against an insurer or health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the plaintiff in the action shall, within 10 days of entry of judgment, provide all of the following to the Commissioner of the Department of Insurance or the Director of the Department of Managed Care, whichever commissioner has regulatory jurisdiction over the insurer or health care service plan:

(1) A copy of the judgment.

(2) A brief recitation of the facts of the case.

(3) Copies of relevant pleadings, as determined by the plaintiff.

(b) The willful failure to comply with this section may, at the discretion of the trial court, result in the imposition of sanctions against the plaintiff or his or her attorney.

(c) This section shall apply to all judgments entered on or after January 1, 1995.

(d) ''Insurer,'' for purposes of this section, means any person or entity transacting any of the classes of insurance described in Chapter 1 (commencing with Section 100) of Part 1 of Division 1 of the Insurance Code.

SEC. 8. Section 10821 of the Corporations Code is amended to read:

10821. Notwithstanding any other provision of this division, as to a health care service plan which is formed under or subject to Part 2 (commencing with Section 5110) or Part 3 (commencing with Section 7110) of this division, all references to the Attorney General contained in Part 2 or Part 3 of this division shall, in the case of health care service plans, be deemed to refer to the Director of the Department of Managed Care.

SEC. 9. Section 13408.5 of the Corporations Code is amended to read:

13408.5. No professional corporation may be formed so as to cause any violation of law, or any applicable rules and regulations, relating to fee splitting, kickbacks, or other similar practices by physicians and surgeons or psychologists, including, but not limited to, Section 650 or subdivision (e) of Section 2960 of the Business and Professions Code. A violation of any such provisions shall be grounds for the suspension or revocation of the certificate of registration of the professional corporation. The Commissioner of Corporations or the

Director of the Department of Managed Care may refer any suspected violation of such provisions to the governmental agency regulating the profession in which the corporation is, or proposes to be engaged.

SEC. 10. Section 1322 of the Government Code is amended to read:

1322. In addition to any other statutory provisions requiring confirmation by the Senate of officers appointed by the Governor, the appointments by the Governor of the following officers and the appointments by him or her to the listed boards and commissions are subject to confirmation by the Senate:

(1) California Horse Racing Board.
(2) Court Reporters Board of California.
(3) Chief, Division of Occupational Safety and Health.
(4) Chief, Division of Labor Standards Enforcement.
(5) Commissioner of Corporations.
(6) Contractors State License Board.
(7) Director of Fish and Game.
(8) State Director of Health Services.
(9) Chief Deputy, State Department of Health Services.
(10) Real Estate Commissioner.
(11) State Athletic Commissioner.
(12) State Board of Barbering and Cosmetology Examiners.
(13) State Librarian.
(14) Director of Social Services.
(15) Chief Deputy, State Department of Social Services.
(16) Director of Mental Health.
(17) Chief Deputy, State Department of Mental Health.
(18) Director of Developmental Services.
(19) Chief Deputy, State Department of Developmental Services.
(20) Director of Alcohol and Drug Abuse.
(21) Director of Rehabilitation.
(22) Chief Deputy, Department of Rehabilitation.
(23) Director of the Office of Statewide Health Planning and Development.
(24) Deputy, Health and Welfare Agency.
(25) Director, Department of Managed Care.
(26) Patient Advocate, Department of Managed Care.

SEC. 11. Section 6253.4 of the Government Code is amended to read:

6253.4. (a) Every agency may adopt regulations stating the procedures to be followed when making its records available in accordance with this section.

The following state and local bodies shall establish written guidelines for accessibility of records. A copy of these guidelines shall be posted in a conspicuous public place at the offices of these bodies,

and a copy of the guidelines shall be available upon request free of charge to any person requesting that body's records:

Department of Motor Vehicles
Department of Consumer Affairs
Department of Transportation
Department of Real Estate
Department of Corrections
Department of the Youth Authority
Department of Justice
Department of Insurance
Department of Corporations
Department of Managed Care
Secretary of State
State Air Resources Board
Department of Water Resources
Department of Parks and Recreation
San Francisco Bay Conservation and Development Commission
State Board of Equalization
State Department of Health Services
Employment Development Department
State Department of Social Services
State Department of Mental Health
State Department of Developmental Services
State Department of Alcohol and Drug Abuse
Office of Statewide Health Planning and Development
Public Employees' Retirement System
Teachers' Retirement Board
Department of Industrial Relations
Department of General Services
Department of Veterans Affairs
Public Utilities Commission
California Coastal Commission
State Water Resources Control Board
San Francisco Bay Area Rapid Transit District
All regional water quality control boards
Los Angeles County Air Pollution Control District
Bay Area Air Pollution Control District
Golden Gate Bridge, Highway and Transportation District
Department of Toxic Substances Control
Office of Environmental Health Hazard Assessment

(b) Guidelines and regulations adopted pursuant to this section shall be consistent with all other sections of this chapter and shall reflect the intention of the Legislature to make the records accessible to the public. The guidelines and regulations adopted pursuant to this section shall not operate to limit the hours public records are open for inspection as prescribed in Section 6253.

SEC. 12. Section 6254.5 of the Government Code is amended to read:

6254.5. Notwithstanding any other provisions of the law, whenever a state or local agency discloses a public record which is otherwise exempt from this chapter, to any member of the public, this disclosure shall constitute a waiver of the exemptions specified in Sections 6254, 6254.7, or other similar provisions of law. For purposes of this section, ''agency'' includes a member, agent, officer, or employee of the agency acting within the scope of his or her membership, agency, office, or employment.

This section, however, shall not apply to disclosures:

(a) Made pursuant to the Information Practices Act (commencing with Section 1798 of the Civil Code) or discovery proceedings.

(b) Made through other legal proceedings or as otherwise required by law.

(c) Within the scope of disclosure of a statute which limits disclosure of specified writings to certain purposes.

(d) Not required by law, and prohibited by formal action of an elected legislative body of the local agency which retains the writings.

(e) Made to any governmental agency which agrees to treat the disclosed material as confidential. Only persons authorized in writing by the person in charge of the agency shall be permitted to obtain the information. Any information obtained by the agency shall only be used for purposes which are consistent with existing law.

(f) Of records relating to a financial institution or an affiliate thereof, if the disclosures are made to the financial institution or affiliate by a state agency responsible for the regulation or supervision of the financial institution or affiliate.

(g) Of records relating to any person that is subject to the jurisdiction of the Department of Corporations, if the disclosures are made to the person that is the subject of the records for the purpose of corrective action by that person, or if a corporation, to an officer, director, or other key personnel of the corporation for the purpose of corrective action, or to any other person to the extent necessary to obtain information from that person for the purpose of an investigation by the Department of Corporations.

(h) Made by the Commissioner of Financial Institutions under Section 1909, 8009, or 18396 of the Financial Code.

(i) Of records relating to any person that is subject to the jurisdiction of the Department of Managed Care, if the disclosures are made to the person that is the subject of the records for the purpose of corrective action by that person, or if a corporation, to an officer, director, or other key personnel of the corporation for the purpose of corrective action, or to any other person to the extent

necessary to obtain information from that person for the purpose of an investigation by the Department of Managed Care.

SEC. 13. Section 11552 of the Government Code is amended to read:

11552. Effective January 1, 1988, an annual salary of eighty-five thousand four hundred two dollars ($85,402) shall be paid to each of the following:

(a) Commissioner of Financial Institutions.
(b) Commissioner of Corporations.
(c) Insurance Commissioner.
(d) Director of Transportation.
(e) Real Estate Commissioner.
(f) Director of Social Services.
(g) Director of Water Resources.
(h) Director of Corrections.
(i) Director of General Services.
(j) Director of Motor Vehicles.
(k) Director of the Youth Authority.
(*l*) Executive Officer of the Franchise Tax Board.
(m) Director of Employment Development.
(n) Director of Alcoholic Beverage Control.
(o) Director of Housing and Community Development.
(p) Director of Alcohol and Drug Abuse.
(q) Director of the Office of Statewide Health Planning and Development.
(r) Director of the Department of Personnel Administration.
(s) Chairperson and Member of the Board of Equalization.
(t) Director of Commerce.
(u) State Director of Health Services.
(v) Director of Mental Health.
(w) Director of Developmental Services.
(x) State Public Defender.
(y) Director of the California State Lottery.
(z) Director of Fish and Game.
(aa) Director of Parks and Recreation.
(ab) Director of Rehabilitation.
(ac) Director of Veterans Affairs.
(ad) Director of Consumer Affairs.
(ae) Director of Forestry and Fire Protection.
(af) Director of the Department of Managed Care.

The annual compensation provided by this section shall be increased in any fiscal year in which a general salary increase is provided for state employees. The amount of the increase provided by this section shall be comparable to, but shall not exceed, the percentage of the general salary increases provided for state employees during that fiscal year.

SEC. 14. Section 13975 of the Government Code is amended to read:

13975. The Business and Transportation Agency in state government is hereby renamed the Business, Transportation and Housing Agency. The agency consists of the Department of Alcoholic Beverage Control, the Department of the California Highway Patrol, the Department of Corporations, the Department of Housing and Community Development, the Department of Motor Vehicles, the Department of Real Estate, the Department of Transportation, the Department of Financial Institutions, the Department of Managed Care, the Stephen P. Teale Consolidated Data Center; and the California Housing Finance Agency is also located within the Business, Transportation and Housing Agency, as specified in Division 31 (commencing with Section 50000) of the Health and Safety Code.

SEC. 15. Section 13975.2 is added to the Government Code, to read:

13975.2. (a) This section applies to every action brought in the name of the people of the State of California by the Director of the Department of Managed Care before, on, or after the effective date of this section, when enforcing provisions of those laws administered by the Director of the Department of Managed Care which authorize the Director of Managed Care to seek a permanent or preliminary injunction, restraining order, or writ of mandate, or the appointment of a receiver, monitor, conservator, or other designated fiduciary or officer of the court. Upon a proper showing, a permanent or preliminary injunction, restraining order, or writ of mandate shall be granted and a receiver, monitor, conservator, or other designated fiduciary or officer of the court may be appointed for the defendant or the defendant's assets, or any other ancillary relief may be granted as appropriate. The court may order that the expenses and fees of the receiver, monitor, conservator, or other designated fiduciary or officer of the court, be paid from the property held by the receiver, monitor, conservator, or other court designated fiduciary or officer, but neither the state, the Business, Transportation and Housing Agency, nor the Department of Managed Care shall be liable for any of those expenses and fees, unless expressly provided for by written contract.

(b) The receiver, monitor, conservator, or other designated fiduciary or officer of the court may do any of the following subject to the direction of the court:

(1) Sue for, collect, receive, and take into possession all the real and personal property derived by any unlawful means, including property with which that property or the proceeds thereof has been commingled if that property or the proceeds thereof cannot be identified in kind because of the commingling.

(2) Take possession of all books, records, and documents relating to any unlawfully obtained property and the proceeds thereof. In addition, they shall have the same right as a defendant to request, obtain, inspect, copy, and obtain copies of books, records, and documents maintained by third parties that relate to unlawfully obtained property and the proceeds thereof.

(3) Transfer, encumber, manage, control, and hold all property subject to the receivership, including the proceeds thereof, in the manner directed or ratified by the court.

(4) Avoid a transfer of any interest in any unlawfully obtained property including the proceeds thereof to any person who committed, aided or abetted, or participated in the commission of unlawful acts or who had knowledge that the property had been unlawfully obtained.

(5) Avoid a transfer of any interest in any unlawfully obtained property including the proceeds thereof made with the intent to hinder or delay the recovery of that property or any interest in it by the receiver or any person from whom the property was unlawfully obtained.

(6) Avoid a transfer of any interest in any unlawfully obtained property including the proceeds thereof that was made within one year before the date of the entry of the receivership order if less than a reasonably equivalent value was given in exchange for the transfer, except that a bona fide transferee for value and without notice that the property had been unlawfully obtained may retain the interest transferred until the value given in exchange for the transfer is returned to the transferee.

(7) Avoid a transfer of any interest in any unlawfully obtained property including the proceeds thereof made within 90 days before the date of the entry of the receivership order to a transferee from whom the defendant unlawfully obtained some property if (A) the receiver establishes that the avoidance of the transfer will promote a fair pro rata distribution of restitution among all people from whom defendants unlawfully obtained property and (B) the transferee cannot establish that the specific property transferred was the same property that had been unlawfully obtained from the transferee.

(8) Exercise any power authorized by statute or ordered by the court.

(c) No person with actual or constructive notice of the receivership shall interfere with the discharge of the receiver's duties.

(d) No person may file any action or enforce or create any lien, or cause to be issued, served, or levied any summons, subpoena, attachment, or writ of execution against the receiver or any property subject to the receivership without first obtaining prior court approval upon motion with notice to the receiver and the Director of the Department of Managed Care. Any legal procedure described

in this subdivision commenced without prior court approval is void except as to a bona fide purchaser or encumbrancer for value and without notice of the receivership. No person without notice of the receivership shall incur any liability for commencing or maintaining any legal procedure described by this subdivision.

(e) The court shall have jurisdiction of all questions arising in the receivership proceedings and may make any orders and judgments as may be required, including orders after noticed motion by the receiver to avoid transfers as provided in paragraphs (4), (5), (6), and (7) of subdivision (b).

(f) This section is cumulative to all other provisions of law.

(g) If any provision of this section or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of this section that can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

(h) The recordation of a copy of the receivership order imparts constructive notice of the receivership in connection with any matter involving real property located in the county in which the receivership order is recorded.

SEC. 16. Section 21661 of the Government Code is amended to read:

21661. (a) The board shall contract with carriers offering long-term care insurance plans and enter into health care service plan contracts covering long-term care.

The long-term care insurance plans and health care service plan contracts covering long-term care shall be made available periodically during open enrollment periods determined by the board.

(b) The board shall award contracts to carriers who are qualified to provide long-term care benefits, and may develop and administer self-funded long-term care insurance plans. The board may offer one or more long-term care insurance plans or health care service plan contracts covering long-term care and may offer service or indemnity-type plans.

(c) The long-term care insurance plans and health care service plan contracts covering long-term care shall include home, community, and institutional care and shall, to the extent determined by the board, provide substantially equivalent coverage to that required under Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code, if the carrier has been approved by the Department of Managed Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(d) The classes of persons who shall be eligible to enroll are:

(1) Active and retired members and annuitants of the Public Employees' System, and their spouses, their parents, and their spouses' parents.

(2) Active and retired members and annuitants of any county or district subject to the County Employees Retirement Law of 1937, and their spouses, their parents, and their spouses' parents.

(3) Active and retired members and annuitants of the State Teachers' Retirement System, and their spouses, their parents, and their spouses' parents.

(4) Active employees and retirees and annuitants of any public agency that is a contracting agency under this part or Part 5 (commencing with Section 22751), and their spouses, their parents, and their spouses' parents.

(5) Active and retired members and annuitants of the Judges' Retirement System, and their spouses, their parents, and their spouses' parents.

(6) Active and retired members and annuitants of the Judges' Retirement System II, and their spouses, their parents, and their spouses' parents.

(7) Active and retired members and annuitants of the Legislators' Retirement System, and their spouses, their parents, and their spouses' parents.

(8) Members of the California Assembly and Senate and their spouse, their parents and their spouse's parents.

(9) Active and retired members and annuitants, and other classes of employees of other public employee retirement systems or public employers as the board determines may be eligible under the standards the board may prescribe, and their spouses, their parents, and their spouses' parents.

(10) Active employees and retirees and annuitants of any agency specified in paragraphs (1) through (9) who reside in the United States, its territories and possessions, or in a country in which a provider network can be established comparable in quality and effectiveness to those established in the United States.

(e) Any California public agency or retirement system may contract with the board to extend the provisions of this article to its active and retired employees and annuitants.

(f) Irrespective of paragraphs (1) through (10) of subdivision (d), no person shall be enrolled unless he or she meets the eligibility and underwriting criteria established by the board.

(g) Irrespective of paragraphs (1) through (10) of subdivision (d), enrollment of active employees of the State of California shall be subject to Section 19867.

(h) The board shall establish eligibility criteria for enrollment, establish appropriate underwriting criteria for potential enrollees, define the scope of covered benefits, define the criteria to receive benefits, and set any other standards as needed.

(i) The full cost of enrollment in a long-term care insurance plan or in health care service plan contracts covering long-term care shall be paid by the enrollees.

(j) The long-term care insurance plans and health care service plan contracts covering long-term care shall not become part of, or subject to, the retirement or health benefits programs administered by the system.

(k) For any self-funded long-term care plan developed by the board, the premiums shall be deposited in the Public Employees' Long-term Care Fund.

SEC. 17. Section 31696.1 of the Government Code is amended to read:

31696.1. (a) The board of retirement may provide a long-term care insurance program for retired members and their spouses, their parents, and their spouses' parents.

(b) Subject to Section 31696.5, the board may permit active members and their spouses, their parents, and their spouses' parents to enroll in the long-term care insurance program.

(c) The long-term care insurance plan shall be made available periodically during open enrollment periods determined by the board.

(d) The board shall award contracts to carriers who are qualified to provide long-term care benefits.

(e) The long-term care insurance plan shall include home, community, and institutional care and shall provide substantially equivalent coverage to that required under Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code and shall meet those requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). However, the Department of Managed Care shall have no jurisdiction over the insurance plan authorized by this article.

(f) Notwithstanding subdivision (a), no person shall be enrolled unless he or she meets the eligibility and underwriting criteria approved by the board.

(g) The board shall approve eligibility criteria for enrollment, approve appropriate underwriting criteria for potential enrollees, approve the scope of covered benefits, approve the criteria to receive benefits, and approve any other standards as needed.

SEC. 18. Section 37615.1 of the Government Code is amended to read:

37615.1. Each local municipal hospital shall have and may exercise the following powers:

(a) To purchase, receive, have, take, hold, lease, use, and enjoy property of every kind and description within and without the limits of the municipality, and to control, dispose of, convey, and encumber

the same and create a leasehold interest in the same for the benefit of the hospital.

(b) To establish one or more trusts for the benefit of the municipal hospital, to administer any trusts declared or created for the benefit of the municipal hospital, to designate one or more trustees for trusts created by the municipality, to receive by gift, devise, or bequest, and hold in trust or otherwise, property, including corporate securities of all kinds, situated in this state or elsewhere, and where not otherwise provided, dispose of the same for the benefit of the municipal hospital.

(c) To employ any officers and employees, including architects and consultants, the board of trustees deems necessary to carry on properly the business of the municipal hospital.

(d) To do any and all things which an individual might do which are necessary for, and to the advantage of, a hospital and a nurses' training school, or a child-care facility for the benefit of employees of the hospital or residents of the municipality.

(e) To establish, maintain and operate, or provide assistance in the operation of, one or more health facilities or health services, including, but not limited to, outpatient programs, services and facilities, retirement programs, services and facilities, chemical dependency programs, services and facilities, or other health care programs, services and facilities and activities at any location within or without the municipality for the benefit of the hospital and the people served by the municipal hospital.

''Health facilities,'' as used in this subdivision, means those facilities defined in either Section 15432 of this code or Section 1250 of the Health and Safety Code and specifically includes freestanding chemical dependency recovery units.

(f) To do any and all other acts and things necessary to carry out this division.

(g) To acquire, maintain, and operate ambulances or ambulance services within and without the municipality.

(h) To establish, maintain, and operate, or provide assistance in the operation of, free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and any other health care services provider, groups, and organizations which are necessary for the maintenance of good physical and mental health in the communities served by the municipal hospital.

(i) To establish and operate in cooperation with its medical staff a coinsurance plan between the municipal hospital and the members of its attending medical staff.

(j) With the approval of the city council, to establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the municipal hospital.

(k) With the consent of the city council, to contract for bond insurance, letters of credit, remarketing services, and other forms of credit enhancement and liquidity support for its bonds, notes, and other indebtedness and to enter into reimbursement agreements, monitoring agreements, remarketing agreements, and similar ancillary contracts in connection therewith.

(*l*) To establish, maintain, operate, participate in, or manage capitated health care plans, health maintenance organizations, preferred provider organizations, and other managed health care systems and programs properly licensed by the Department of Insurance or the Department of Managed Care, at any location within or without the municipality for the benefit of residents of communities served by the hospital. However, no such activity shall be deemed to result in or constitute the giving or lending of the municipality's credit, assets, surpluses, cash, or tangible goods to, or in aid of, any person, association, or corporation in violation of Section 6 of Article XVI of the California Constitution.

Nothing in this section shall authorize activities which corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the Business and Professions Code.

Any agreement to provide health care coverage which is a health care service plan, as defined in subdivision (f) of Section 1345 of the Health and Safety Code, shall be subject to the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, unless exempted pursuant to Section 1343 or 1349.2 of the Health and Safety Code.

A municipal hospital shall not provide health care coverage for any employee of an employer operating within the service area of the municipal hospital, unless the Legislature specifically authorizes, or has authorized the coverage.

This section shall not authorize any municipal hospital to contribute its facilities to any joint venture that could result in transfer of the facilities from city ownership.

(m) To provide health care coverage to members of the hospital's medical staff, employees of the medical staff members, and the dependents of both groups, on a self-pay basis.

(n) With the consent of the city council, to establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the municipal hospital.

(o) With the consent of the city council, to transfer, with or without consideration, any part of its assets to one or more nonprofit corporations to operate and maintain the assets for the benefits of the area served by the hospital. The initial members of the board of directors of the nonprofit corporation or corporations shall be approved by the city council and shall be residents of the city.

(p) Nothing in this section, including, but not limited to, subdivision (e), shall be construed to permit a municipal hospital to

operate or be issued a single consolidated license to operate a separate physical plant as a skilled nursing facility or an intermediate care facility which is not located within the boundaries of the municipality.

SEC. 19. Section 1317.2a of the Health and Safety Code is amended to read:

1317.2a. (a) A hospital which has a legal obligation, whether imposed by statute or by contract, to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, a county, or an employer to provide care for a patient under the circumstances specified in Section 1317.2 shall receive that patient to the extent required by the applicable statute or by the terms of the contract, or, when the hospital is unable to accept a patient for whom it has a legal obligation to provide care whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care.

(b) A county hospital shall accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2 and who is determined by the county to be eligible to receive health care services required under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, unless the hospital does not have appropriate bed capacity, medical personnel, or equipment required to provide care to the patient in accordance with accepted medical practice. When a county hospital is unable to accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care. The obligation to make appropriate arrangements as set forth in this subdivision does not mandate a level of service or payment, modify the county's obligations under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, create a cause of action, or limit a county's flexibility to manage county health systems within available resources. However, the county's flexibility shall not diminish a county's responsibilities under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code or the requirements contained in Chapter 2.5 (commencing with Section 1440).

(c) The receiving hospital shall provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient.

(d) Any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, or employer which has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall

be liable, to the extent of the contractual obligation to the patient, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for uncovered services, or any deductible or copayment obligation. Notwithstanding this section, the liability of a third-party payor which has contracted with health care providers for the provision of these emergency services shall be set by the terms of that contract. Notwithstanding this section, the liability of a third-party payor that is licensed by the Insurance Commissioner or the Director of the Department of Managed Care and has a contractual obligation to provide or indemnify emergency medical services under a contract which covers a subscriber or an enrollee shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(e) A hospital which has a legal obligation to provide care for a patient as specified by subdivision (a) of Section 1317.2a to the extent of its legal obligation, imposed by statute or by contract to the extent of that contractual obligation, which does not accept transfers of, or make other appropriate arrangements for, medically stable patients in violation of this article or regulations adopted pursuant thereto shall be liable for the reasonable charges of the transferring hospital and treating physicians for providing services and care which should have been provided by the receiving hospital.

(f) Subdivisions (d) and (e) do not apply to county obligations under Section 17000 of the Welfare and Institutions Code.

(g) Nothing in this section shall be interpreted to require a hospital to make arrangements for the care of a patient for whom the hospital does not have a legal obligation to provide care.

SEC. 20. Section 1317.6 of the Health and Safety Code is amended to read:

1317.6. (a) Hospitals found by the state department to have committed or to be responsible for a violation of this article or the regulations adopted pursuant thereto shall be subject to a civil penalty by the state department in an amount not to exceed twenty-five thousand dollars ($25,000) for each hospital violation. In determining the amount of the fine for a hospital violation, the state department shall take into account all of the following:

(1) Whether the violation was knowing or unintentional.

(2) Whether the violation resulted or was reasonably likely to result in a medical hazard to the patient.

(3) The frequency or gravity of the violation.

(4) Other civil fines which have been imposed as a result of the violation under Section 1395 of Title 42 of the United States Code.

(b) Notwithstanding this section, the director shall refer any alleged violation by a hospital owned and operated by a health care service plan involving a plan member or enrollee to the Department

of Managed Care unless the director determines the complaint is without reasonable basis. The Department of Managed Care shall have sole authority and responsibility to enforce this article with respect to violations involving hospitals owned and operated by health care service plans in their treatment of plan members or enrollees.

(c) Physicians and surgeons found by the board to have committed, or to be responsible for, a violation of this article or the regulations adopted pursuant thereto shall be subject to any and all penalties which the board may lawfully impose and may be subject to a civil penalty by the board in an amount not to exceed five thousand dollars ($5,000) for each violation. A civil penalty imposed under this subdivision shall not duplicate federal fines, and the board shall credit any federal fine against a civil penalty imposed under this subdivision.

(d) The board may impose fines when it finds any of the following:

(1) The violation was knowing or willful.

(2) The violation was reasonably likely to result in a medical hazard.

(3) There are repeated violations.

(e) It is the intent of the Legislature that the state department has primary responsibility for regulating the conduct of hospital emergency departments and that fines imposed under this section should not be duplicated by additional fines imposed by the federal government as a result of the conduct which constituted a violation of this section. To effectuate the Legislature's intent, the Governor shall inform the Secretary of the federal Department of Health and Human Services of the enactment of this section and request the federal department to credit any penalty assessed under this section against any subsequent civil monetary penalty assessed pursuant to Section 1395dd of Title 42 of the United States Code for the same violation.

(f) There shall be a cumulative maximum limit of thirty thousand dollars ($30,000) in fines assessed against hospitals under this article and under Section 1395dd of Title 42 of the United States Code for the same circumstances. To effectuate this cumulative maximum limit, the state department shall do both of the following:

(1) As to state fines assessed prior to the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1395dd of Title 42 of the United States Code (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), remit and return to the hospital within 30 days after conclusion of the federal action, that portion of the state fine necessary to assure that the cumulative maximum limit is not exceeded.

(2) Immediately credit against state fines assessed after the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1395dd of Title 42 of the United States Code, which results in a fine against a hospital (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), the amount of the federal fine, necessary to assure the cumulative maximum limit is not exceeded.

(g) Any hospital found by the state department pursuant to procedures established by the state department to have committed a violation of this article or the regulations adopted hereunder may have its emergency medical service permit revoked or suspended by the state department.

(h) Any administrative or medical personnel who knowingly and intentionally violates any provision of this article, may be charged by the local district attorney with a misdemeanor.

(i) Notification of each violation found by the state department of the provisions of this article or the regulations adopted hereunder shall be sent by the state department to the Joint Commission for the Accreditation of Hospitals, the state emergency medical services authority, and local emergency medical services agencies.

(j) Any person who suffers personal harm and any medical facility which suffers a financial loss as a result of a violation of this article or the regulations adopted hereunder may recover, in a civil action against the transferring or receiving hospital, damages, reasonable attorney's fees, and other appropriate relief. Transferring and receiving hospitals from which inappropriate transfers of persons are made or refused in violation of this article and the regulations adopted hereunder shall be liable for the reasonable charges of the receiving or transferring hospital for providing the services and care which should have been provided. Any person potentially harmed by a violation of this article or the regulations adopted hereunder, or the local district attorney or the Attorney General, may bring a civil action against the responsible hospital or administrative or medical personnel, to enjoin the violation, and if the injunction issues, the court shall award reasonable attorney's fees. The provisions of this subdivision are in addition to other civil remedies and do not limit the availability of the other remedies.

(k) The civil remedies established by this section do not apply to violations of any requirements established by any county or county agency.

SEC. 21. Section 1341 of the Health and Safety Code is repealed.

SEC. 22. Section 1341 is added to the Health and Safety Code, to read:

1341. (a) There is in state government, in the Business, Transportation and Housing Agency, a Department of Managed

Care that has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.

(b) The chief officer of the Department of Managed Care is the Director of the Department of Managed Care. The director shall be appointed by the Governor and shall hold office at the pleasure of the Governor. The director shall receive an annual salary as fixed in the Government Code. Within 15 days from the time of the director's appointment, the director shall take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

(c) The director shall be responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws described in subdivision (a).

SEC. 23. Section 1341.1 is added to the Health and Safety Code, to read:

1341.1. The director shall have his or her principal office in the City of Sacramento, and may establish branch offices in the City and County of San Francisco, in the City of Los Angeles, and in the City of San Diego. The director shall from time to time obtain the necessary furniture, stationery, fuel, light, and other proper conveniences for the transaction of the business of the Department of Managed Care.

SEC. 24. Section 1341.2 is added to the Health and Safety Code, to read:

1341.2. In accordance with the laws governing the state civil service, the director shall employ and, with the approval of the Department of Finance, fix the compensation of such personnel as the director needs to discharge properly the duties imposed upon the director by law, including, but not limited to, a chief deputy, a public information officer, a chief enforcement counsel, and legal counsel to act as the attorney for the director in actions or proceedings brought by or against the director under or pursuant to any provision of any law under the director's jurisdiction, or in which the director joins or intervenes as to a matter within the director's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the director or before a person authorized by the director. The personnel of the Department of Managed Care shall perform such duties as the director assigns to them. Such employees as the director designates by rule or order shall, within 15 days after their

appointments, take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

SEC. 25. Section 1341.3 is added to the Health and Safety Code, to read:

1341.3. The director shall adopt a seal bearing the inscription: ''Director, Department of Managed Care, State of California.'' The seal shall be affixed to or imprinted on all orders and certificates issued by him or her and such other instruments as he or she directs. All courts shall take judicial notice of this seal.

SEC. 26. Section 1341.4 is added to the Health and Safety Code, to read:

1341.4. In order to effectively support the Department of Managed Care in the administration of this law, there is hereby established in the State Treasury, the Managed Care Fund. The administration of the Department of Managed Care shall be supported from the Managed Care Fund.

SEC. 27. Section 1341.5 is added to the Health and Safety Code, to read:

1341.5. (a) The director, as a general rule, shall publish or make available for public inspection any information filed with or obtained by the department, unless the director finds that this availability or publication is contrary to law. No provision of this chapter authorizes the director or any of the director's assistants, clerks, or deputies to disclose any information withheld from public inspection except among themselves or when necessary or appropriate in a proceeding or investigation under this chapter or to other federal or state regulatory agencies. No provision of this chapter either creates or derogates from any privilege that exists at common law or otherwise when documentary or other evidence is sought under a subpoena directed to the director or any of his or her assistants, clerks, or deputies.

(b) It is unlawful for the director or any of his or her assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the director and that is not then generally available to the public.

SEC. 28. Section 1341.6 is added to the Health and Safety Code, to read:

1341.6. (a) The Attorney General shall render to the director opinions upon all questions of law, relating to the construction or interpretation of any law under the director's jurisdiction or arising in the administration thereof, that may be submitted to the Attorney General by the director and upon the director's request shall act as the attorney for the director in actions and proceedings brought by or against the director under or pursuant to any provision of any law under the director's jurisdiction.

(b) Sections 11041, 11042, and 11043 of the Government Code do not apply to the Director of the Department of Managed Care.

SEC. 29. Section 1341.7 is added to the Health and Safety Code, to read:

1341.7. (a) Neither the director nor any of the director's assistants, clerks, or deputies shall be interested as a director, officer, shareholder, member other than a member of an organization formed for religious purposes, partner, agent, or employee of any person who, during the period of the official's or employee's association with the Department of Managed Care, was licensed or applied for license as a health care service plan under this chapter.

(b) Nothing contained in subdivision (a) shall prohibit the holdings or purchasing of any securities by the director, an assistant, clerk, or deputy in accordance with rules which shall be adopted for the purpose of protecting the public interest and avoiding conflicts of interest.

SEC. 30. Section 1341.8 is added to the Health and Safety Code, to read:

1341.8. The director shall have the powers of a head of a department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code. The director may make the agreements that he or she deems necessary or appropriate in exercising his or her powers.

SEC. 31. Section 1341.9 is added to the Health and Safety Code, to read:

1341.9. The director and department succeed to, and are vested with, all duties, powers, purposes, responsibilities, and jurisdiction of the Commissioner of Corporations and the Department of Corporations as they relate to the Department of Corporations' Health Plan Program, health care service plans, and the health care service plan business, including those powers and duties specified in this chapter. Nothing in this section abrogates, limits, diminishes, or otherwise restricts the duties, powers, purposes, responsibilities, and jurisdictions of the Commissioner of Corporations and the Department of Corporations under the Investment Program, the Financial Services Program, and the other laws in which jurisdiction is vested in the Commissioner of Corporations and the Department of Corporations.

SEC. 32. Section 1341.10 is added to the Health and Safety Code, to read:

1341.10. The department may use the unexpended balance of funds available for use in connection with the performance of the functions of the Department of Corporations to which the department succeeds pursuant to Section 1341.9.

SEC. 33. Section 1341.11 is added to the Health and Safety Code, to read:

1341.11. All officers and employees of the Department of Corporations who, on the operative date of this section, are performing any duty, power, purpose, responsibility, or jurisdiction

to which the department succeeds, who are serving in the state civil service, other than as temporary employees, and engaged in the performance of a function vested by the department by Section 1341.9, shall be transferred to the department. The status, positions, and rights of those persons shall not be affected by the transfer and shall be retained by those persons as officers and employees of the department, pursuant to the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code), except as to positions exempted from civil service.

SEC. 34. Section 1341.12 is added to the Health and Safety Code, to read:

1341.12. The department shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, licenses, permits, agreements, contracts, claims, judgments, land, and other property, real or personal, connected with the administration of, or held for the benefit or use of, the Department of Corporations for the performance of the functions transferred to the department by Section 1341.9.

SEC. 35. Section 1341.13 is added to the Health and Safety Code, to read:

1341.13. All officers or employees of the department employed after the operative date of this section shall be appointed by the director.

SEC. 36. Section 1341.14 is added to the Health and Safety Code, to read:

1341.14. (a) Any regulation, order, or other action, adopted, prescribed, taken, or performed by the Department of Corporations or by an officer of the Department of Corporations in the administration of a program or the performance of a duty, responsibility, or authorization transferred to the department by Section 1341.9 shall remain in effect and shall be deemed to be a regulation, order, or action of the department.

(b) No suit, action, or other proceeding lawfully commenced by or against the Department of Corporations or any other officer of the state, in relation to the administration of any program or the discharge of any duty, responsibility, or authorization transferred to the department by Section 1341.9 shall abate by reason of the transfer of the program, duty, responsibility, or authorization.

SEC. 37. Section 1342 of the Health and Safety Code is amended to read:

1342. It is the intent and purpose of the Legislature to promote the delivery of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:

(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

(b) Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace.

(c) Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public.

(d) Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Ensuring the financial stability thereof by means of proper regulatory procedures.

(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

(h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department.

SEC. 38. Section 1342.3 is added to the Health and Safety Code, to read:

1342.3. The director shall, in conjunction with the Advisory Committee on Managed Care, undertake a study to consider the feasibility and benefit of consolidating into the Department of Managed Care the regulation of other health insurers providing insurance through indemnity, preferred provider organization, and exclusive provider organization products, as well as through other managed care products regulated by the Department of Insurance. The results of the study along with the recommendations of the director shall be incorporated into a report to the Governor and the Legislature no later than December 31, 2001.

SEC. 39. Section 1342.5 of the Health and Safety Code is amended to read:

1342.5. The director shall consult with the Insurance Commissioner prior to adopting any regulations applicable to health care service plans subject to this chapter and nonprofit hospital service plans subject to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code and other entities governed by the Insurance Code for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to these plans and entities by the Insurance Commissioner and the Director of the Department of Managed Care.

SEC. 40. Section 1343 of the Health and Safety Code is amended to read:

1343. (a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (n) of Section 1345.

(b) The director may by the adoption of rules or the issuance of orders deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The director, upon request of the Director of Health Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of Health Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The director may exempt non-county-operated pilot programs upon request of the State Director of Health Services. Those exemptions may be subject to conditions the Director of Health Services deems appropriate.

(d) Upon the request of the Director of Mental Health, the director may exempt from this chapter any mental health plan contractor or any capitated rate contract under Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions Code. Those exemptions may be subject to conditions the Director of Mental Health deems appropriate.

(e) This chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

(3) A nonprofit corporation formed under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(4) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569).

(C) Has obtained a certificate of authority from the State Department of Social Services.

(5) The Major Risk Medical Insurance Board when engaging in activities under Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code, and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code.

(6) The California Small Group Reinsurance Fund.

SEC. 41. Section 1344 of the Health and Safety Code is amended to read:

1344. (a) The director may from time to time adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of this chapter. For the purpose of rules and forms, the director may classify persons and matters within the director's jurisdiction, and may prescribe different requirements for different classes. The director may waive any requirement of any rule or form in situations where in the director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. The director may adopt rules consistent with federal regulations and statutes to regulate health care coverage supplementing Medicare.

(b) The director may honor requests from interested parties for interpretive opinions.

(c) No provision of this chapter imposing any liability applies to any act done or omitted in good faith in conformity with any rule, form, order, or written interpretive opinion of the director, or any such opinion of the Attorney General, notwithstanding that the rule, form, order, or written interpretive opinion may later be amended or rescinded or be determined by judicial or other authority to be invalid for any reason.

SEC. 42. Section 1345 of the Health and Safety Code is amended to read:

1345. As used in this chapter:

(a) ''Advertisement'' means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) ''Basic health care services'' means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. ‘‘Basic health care services’’ includes ambulance and ambulance transport services provided through the ‘‘911’’ emergency response system.

(c) ‘‘Enrollee’’ means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) ‘‘Evidence of coverage’’ means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) ‘‘Group contract’’ means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(f) ‘‘Health care service plan’’ or ‘‘specialized health care service plan’’ means either of the following:

(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(g) ‘‘License’’ means, and ‘‘licensed’’ refers to, a license as a plan pursuant to Section 1353.

(h) ‘‘Out-of-area coverage,’’ for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee’s health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan’s service area.

(i) ‘‘Provider’’ means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) ‘‘Person’’ means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) ‘‘Service area’’ means a geographical area designated by the plan within which a plan shall provide health care services.

(*l*) ‘‘Solicitation’’ means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(m) ‘‘Solicitor’’ means any person who engages in the acts defined in subdivision (1) of this section.

(n) ‘‘Solicitor firm’’ means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (1) of this section.

(o) ‘‘Specialized health care service plan contract’’ means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(p) ‘‘Subscriber’’ means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(q) Unless the context indicates otherwise, ‘‘plan’’ refers to health care service plans and specialized health care service plans.

(r) ‘‘Plan contract’’ means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

(s) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters which they purport to present, subject to any specific requirement imposed by this chapter or by the director.

SEC. 43. Section 1346 of the Health and Safety Code is amended to read:

1346. (a) The director shall administer and enforce this chapter and shall have the following powers:

(1) Recommend and propose the enactment of any legislation necessary to protect and promote the interests of the public, subscribers, enrollees, and providers of health care services in health care service plans in the State of California.

(2) Provide information to federal and state legislative committees and executive agencies concerning plans.

(3) Assist, advise, and cooperate with federal, state, and local agencies and officials to protect and promote the interests of plans, subscribers, enrollees, and the public.

(4) Study, investigate, research, and analyze matters affecting the interests of plans, subscribers, enrollees, and the public.

(5) Hold public hearings, subpoena witnesses, take testimony, compel the production of books, papers, documents, and other evidence, and call upon other state agencies for information to implement the purposes, and enforce this chapter.

(6) Conduct audits and examinations of the books and records of plans and other persons subject to this chapter, and may prescribe by rule or order, but is not limited to, the following:

(A) The form and contents of financial statements required under this chapter.

(B) The circumstances under which consolidated statements shall be filed.

(C) The circumstances under which financial statements shall be audited by independent certified public accountants or public accountants.

(7) Conduct necessary onsite medical surveys of the health delivery system of each plan.

(8) Propose, develop, conduct, and assist in educational programs for the public, subscribers, enrollees, and licensees.

(9) Promote and establish standards of ethical conduct for the administration of plans and undertake activities to encourage responsibility in the promotion and sale of plan contracts and the enrollment of subscribers or enrollees in the plans.

(10) Advise the Governor on all matters affecting the interests of plans, subscribers, enrollees, and the public.

(11) Determine that investments of a plan's assets necessary to meet the requirements of Section 1376 are acceptable. For those purposes, reinvestment in the plan and investment in any obligations set forth in Article 3 (commencing with Section 1170) of, and Article 4 (commencing with Section 1190) of, Chapter 2 of Part 2 of Division 1 of the Insurance Code shall be considered acceptable. All other assets shall be invested in a prudent manner.

(b) The powers enumerated in subdivision (a) shall not limit, diminish, or otherwise restrict the other powers of the director specifically set forth in this chapter and other laws.

SEC. 44. Section 1346.4 of the Health and Safety Code is amended to read:

1346.4. (a) The Legislature finds and declares all of the following:

(1) That millions of Californians are insured under health care service plans regulated by the Knox-Keene Health Care Service Plan Act of 1975, and that more Californians each year are insuring themselves under these health plans.

(2) That greater awareness of the rights and protections afforded by the Knox-Keene Health Care Service Plan Act of 1975 will further the act's goal of providing access to quality health care.

(3) That the public, Knox-Keene providers, and those seeking to form health care service plans under the act will benefit from having the text of the act available to them, affording a greater understanding of what the act does and making it easier for providers to comply with its provisions.

(b) The director shall annually publish this chapter and make it available for sale to the public.

SEC. 45. Section 1346.5 of the Health and Safety Code is amended to read:

1346.5. If the director determines that an entity purporting to be a health care service plan exempt from the provisions of Section 740 of the Insurance Code is not a health care service plan, the director shall inform the Department of Insurance of that finding. However, if the director determines that an entity is a health care service plan, the director shall prepare and maintain for public inspection a list of those persons or entities described in subdivision (a) of Section 740 of the Insurance Code, which are not subject to the jurisdiction of another agency of this or another state or the federal government and which the director knows to be operating in the state. There shall be no liability of any kind on the part of the state, the director, and employees of the Department of Managed Care for the accuracy of the list or for any comments made with respect to it. Additionally, any solicitor or solicitor firm who advertises or solicits health care service plan coverage in this state described in subdivision (a) of Section 740 of the Insurance Code, which is provided by any person or entity described in subdivision (c) of that section, and where such coverage does not meet all pertinent requirements specified in the Insurance Code, and which is not provided or completely underwritten, insured or otherwise fully covered by a health care service plan, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, all financial and operational information relative to the content and scope of the plan and, specifically, as to the lack of plan coverage.

SEC. 46. Section 1347 of the Health and Safety Code is amended to read:

1347. (a) (1) There is established in the Department of Managed Care the Advisory Committee on Managed Care consisting of 22 members, as follows:

(A) The director.

(B) Eleven members appointed by the Governor, to be appointed as follows:

(i) A physician and surgeon with five years' experience in providing services to enrollees of a full service health care service plan.

(ii) An executive officer or medical director of a full service health care service plan.

(iii) A person with expertise and five years' experience in an administrative capacity of a health care service plan.

(iv) An executive officer with five years' experience with a contracting medical group.

(v) A medical director with a contracting medical group.

(vi) A member of the department's Financial Solvency Standards Board.

(vii) A physician-executive from an academic medical center.

(viii) A member of the department's clinical advisory panel.

(ix) A medical director or senior officer with a dental service plan.

(x) A medical director or senior officer with a vision service plan.

(xi) A medical director or senior officer with a mental health service plan.

(C) (i) Ten public members, four of whom shall be appointed by the Governor and three each by the Speaker of the Assembly and the Senate Committee on Rules who have a broad understanding of health and managed care issues and who have no financial interest in the delivery of health care services or in plans except that public members may be enrollees in a health care service plan or specialized health care service plan.

(ii) Of the public members appointed by the Governor, at least two of these members shall have significant academic backgrounds in the area.

(iii) Of the members appointed by the Speaker of the Assembly and the Senate Committee on Rules at least one public member appointed by each appointing power shall represent a health care consumer advocacy organization, with the Speaker's appointee representing an organization that devotes at least 50 percent of its time to resolving consumer complaints. The Speaker of the Assembly and the Senate Committee on Rules shall also each appoint one public member with significant background experience in the area of health care.

(D) With respect to members appointed by the Governor, if members with the qualifications specified in this subdivision are not available for service, other factors such as relevant health care experience and education shall be substituted at the discretion of the Governor.

(2) Except as otherwise specified in this paragraph, all appointments to the committee shall be for a period of three years. The initial appointments shall commence January 1, 2000. Of the initial appointments made by the Governor, four shall serve for a term of one year and five shall serve for a term of two years, as designated by the Governor. Of the initial appointments made by the Speaker of the Assembly and the Senate Committee on Rules, one member appointed by each appointing power shall serve for a term of one year, and one shall serve for a term of two years, as designated by the appointing power.

(b) The committee shall meet at least quarterly and at the call of the chairperson. The director or the director's designee shall be chairperson of the committee. The committee may establish its own rules and procedures. All members shall serve without compensation, but the consumer representatives and public members shall be reimbursed from department funds for expenses actually and necessarily incurred by them in the performance of their duties.

(c) The purpose of the committee is to assist and advise the director in the implementation of the director's duties under this chapter and to make recommendations that it deems beneficial and appropriate as to how the department may best serve the people of the state. The committee shall produce an Internet-accessible annual public report that will, at a minimum, contain recommendations made to the director. At a minimum, the report shall include the following:

(1) Recommendations to the director on producing a report card to the public on the comparative performance of the managed care organizations overseen by the department, including health care service plans and subcontracting providers, building on the work of the private sector and other government entities and including complaint information received by the state.

(2) (A) The committee's top five recommendations for improving the health care delivery system and quality of care taking into consideration information received from the public.

(B) To assist the committee in formulating its recommendations, the views and suggestions of the public should be solicited. The committee shall accompany the director at least twice each year for public hearings (with at least one in northern California and at least one in southern California).

(C) This report shall be delivered to the director, the Governor, and to the appropriate policy committees of the Legislature.

(d) The director shall consult with the advisory committee on regulations and the recommendations of the committee shall be made a part of the record with regard to such regulations. The committee shall be given at least 40 days to review and comment on regulations prior to setting a notice of hearing for proposed regulations. Nothing in this subdivision prohibits the director from promulgating emergency regulations pursuant to the provisions of the Administrative Procedure Act. The director shall discuss budget changes relating to the administration of this chapter with the committee, and the committee may make recommendations to the director regarding the proposed budget changes.

SEC. 47. Section 1347.1 is added to the Health and Safety Code, to read:

1347.1. There is established in the department a Clinical Advisory Panel consisting of five members appointed by the director. These

members shall be professors of medicine from California's public and private medical schools and, additionally, two of the members shall be practicing physicians. The purpose of the advisory panel shall be to provide expert assistance to the director in ensuring that the external independent review system is meeting the quality standards necessary to protect the public's interest. The panel shall also assist the director with other clinical issues as needed, such as recommending approaches to globally reducing clinical errors, improving patient safety, increasing the practice of evidence-based medicine, and catalyzing clinical studies when a clear need for additional clinical evidence becomes evident. The panel shall review the decisions made in external review to ensure that the decisions are consistent with best practices and make recommendations for improvements where necessary. The panel shall meet quarterly and shall have staff provided as necessary.

SEC. 48. Section 1348 of the Health and Safety Code is amended to read:

1348. (a) Every health care service plan licensed to do business in this state shall establish an antifraud plan. The purpose of the antifraud plan shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. The antifraud plan elements shall include, but not be limited to, all of the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency.

(b) Every plan shall submit its antifraud plan to the department no later than July 1, 1999. Any changes shall be filed with the department pursuant to Section 1352. The submission shall describe the manner in which the plan is complying with subdivision (a), and the name and telephone number of the contact person to whom inquiries concerning the antifraud plan may be directed.

(c) Every health care service plan that establishes an antifraud plan pursuant to subdivision (a) shall provide to the director an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by the plan, this report shall include the number of cases prosecuted to the extent known by the plan. This report may also include recommendations by the plan to improve efforts to combat health care fraud.

(d) Nothing in this section shall be construed to limit the director's authority to implement this section in accordance with Section 1344.

(e) For purposes of this section, ''fraud'' includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.

(f) Nothing in this section shall be construed to limit any civil, criminal, or administrative liability under any other provision of law.

SEC. 49. Section 1349 of the Health and Safety Code is amended to read:

1349. It is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the director a license, then in effect, as a plan or unless such person is exempted by the provisions of Section 1343 or a rule adopted thereunder. A person licensed pursuant to this chapter need not be licensed pursuant to the Insurance Code to operate a health care service plan or specialized health care service plan unless the plan is operated by an insurer, in which case the insurer shall also be licensed by the Insurance Commissioner.

SEC. 50. Section 1349.2 of the Health and Safety Code is amended to read:

1349.2. (a) A health care service plan, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies all of the following criteria is exempt from this chapter:

(1) Provides services or reimbursement only to employees, retirees, and the dependents of those employees and retirees, of any participating city, county, city and county, public entity, or political subdivision, but not to the general public.

(2) Provides funding for the program.

(3) Provides that providers are reimbursed solely on a fee-for-service basis, so that providers are not at risk in contracting arrangements.

(4) Complies with Section 1378 and, to the extent that a plan contracts directly with providers for health care services, complies with Section 1379.

(5) Does not reduce or change current benefits except in accordance with collective bargaining agreements, or as otherwise authorized by the governing body in the case of unrepresented employees, and provides, pays for, or reimburses at least part of the cost of all basic health care services as defined in subdivision (b) of Section 1345. Plans covering only a single specialized health care service, including dental, vision, or mental health services, shall not be required to cover all basic health care services.

(6) Refrains from any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code, and notifies enrollees of their right to file complaints with the director regarding any violation of this exemption.

(7) Maintains a fiscally sound operation and makes adequate provision against the risk of insolvency so that enrollees are not at risk, individually or collectively, as evidenced by audited financial statements submitted to the director as of the end of the plan's fiscal year, within 180 days after the close of that fiscal year. The financial statements shall be accompanied by a report, certificate, or opinion of an independent certified public accountant. The financial statements shall be prepared in accordance with generally accepted accounting principles. The audit shall be conducted in accordance with generally accepted auditing standards. However, audits of public entities or political subdivisions shall be conducted in accordance with governmental auditing standards. Upon request, the governing body of the plan shall provide copies thereof, without charge, to any enrollee or recognized and participating employee organization.

(8) Submits with the annual financial statements required under paragraph (7), a declaration, which shall conform to Section 2015.5 of the Code of Civil Procedure, executed by a plan official authorized by the governing body of the plan, that the plan complies with this subdivision.

(b) The director's responsibilities under this section shall be limited to enforcing compliance with this section. Nothing in this section shall impair or impede the director's enforcement authority or the remedies available under this chapter, including, but not limited to, the termination of the plan's exemption under this section.

(c) A public joint labor management trust is a trust maintained by one or more participating cities, counties, cities and counties, public entities, or political subdivisions that appoint management representatives, and one or more recognized and participating employee organizations representing the employees of one or more of the cities, counties, cities and counties, public entities, or political subdivisions that appoint labor representatives, in which the management representatives and the labor representatives have equal voting power in the operation of the trust.

(d) A public joint labor management trust shall not be deemed to provide services or reimbursement to the general public if, in addition to providing services or reimbursement to the persons described in paragraph (1) of subdivision (a), it provides services or reimbursement only to employees, retirees, and dependents of those employees and retirees, of the recognized and participating employee organizations or of the trust.

(e) Nothing in this section shall be construed to prohibit a recognized and participating employee organization from filing a complaint with the director regarding a violation of this section.

SEC. 51. Section 1351 of the Health and Safety Code is amended to read:

1351. Each application for licensure as a health care service plan or specialized health care service plan under this chapter shall be verified by an authorized representative of the applicant, and shall be in a form prescribed by the department. Such application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall set forth or be accompanied by each and all of the following:

(a) The basic organizational documents of the applicant; such as, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto.

(b) A copy of the bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.

(c) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, which shall include among others, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, each shareholder with over 5-percent interest in the case of a corporation, and all partners or members in the case of a partnership or association, and each person who has loaned funds to the applicant for the operation of its business.

(d) A copy of any contract made, or to be made, between the applicant and any provider of health care services, or persons listed in subdivision (c), or any other person or organization agreeing to perform an administrative function or service for the plan. The director by rule may identify contracts excluded from this requirement and make provision for the submission of form contracts. The payment rendered or to be rendered to such provider of health care services shall be deemed confidential information that shall not be divulged by the director, except that such payment may be disclosed and become a public record in any legislative, administrative, or judicial proceeding or inquiry. The plan shall also submit the name and address of each physician employed by or contracting with the plan, together with his or her license number.

(e) A statement describing the plan, its method of providing for health care services and its physical facilities. If applicable, this statement shall include the health care delivery capabilities of the plan including the number of full-time and part-time primary physicians, the number of full-time and part-time and specialties of all nonprimary physicians; the numbers and types of licensed or state-certified health care support staff, the number of hospital beds

contracted for, and the arrangements and the methods by which health care services will be provided. For purposes of this subdivision, primary physicians include general and family practitioners, internists, pediatricians, obstetricians, and gynecologists.

(f) A copy of the forms of evidence of coverage and of the disclosure forms or material which are to be issued to subscribers or enrollees of the plan.

(g) A copy of the form of the individual contract which is to be issued to individual subscribers and the form of group contract which is to be issued to any employers, unions, trustees, or other organizations.

(h) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant. However, financial statements from public entities or political subdivisions of the state need not include a report, certificate, or opinion by an independent certified public accountant if the financial statement complies with such requirements as may be established by regulation of the director.

(i) A description of the proposed method of marketing the plan and a copy of any contract made with any person to solicit on behalf of the plan or a copy of the form of agreement used and a list of the contracting parties.

(j) A power of attorney duly executed by any applicant, not domiciled in this state, appointing the director the true and lawful attorney in fact of such applicant in this state for the purposes of service of all lawful process in any legal action or proceeding against the plan on a cause of action arising in this state.

(k) A statement describing the service area or areas to be served, including the service location for each provider rendering professional services on behalf of the plan and the location of any other plan facilities where required by the director.

(*l*) A description of enrollee-subscriber grievance procedures to be utilized as required by this chapter, and a copy of the form specified by subdivision (c) of Section 1368.

(m) A description of the procedures and programs for internal review of the quality of health care pursuant to the requirements set forth in this chapter.

(n) A description of the mechanism by which enrollees and subscribers will be afforded an opportunity to express their views on matters relating to the policy and operation of the plan.

(o) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of health care services.

(p) Evidence of adequate insurance coverage or self-insurance to protect against losses of facilities where required by the director.

(q) If required by the director by rule pursuant to Section 1376, a fidelity bond or a surety bond in the amount prescribed.

(r) Evidence of adequate workmen's compensation insurance coverage to protect against claims arising out of work-related injuries that might be brought by the employees and staff of a plan against the plan.

(s) Such other information as the director may reasonably require.

SEC. 52. Section 1351.1 of the Health and Safety Code is amended to read:

1351.1. In addition to the requirements of Section 1351 and upon request of the director, each application shall be accompanied by authorization for disclosure to the director of financial records of each health care service plan or specialized health care service plan licensed under this chapter pursuant to Section 7473 of the Government Code. For the purpose of this chapter, the authorization for disclosure shall also include the financial records of any association, partnership or corporation controlling, controlled by or otherwise affiliated with a health care service plan or specialized health care service plan.

SEC. 53. Section 1351.2 of the Health and Safety Code is amended to read:

1351.2. (a) If a health care service plan licensed under the laws of Mexico elects to operate a health care service plan in this state, the plan shall apply for licensure as a health care service plan under this chapter by filing an application for licensure in the form prescribed by the department and verified by an authorized representative of the applicant. The plan shall be subject to the provisions of this chapter, and the rules adopted by the director thereunder, as determined by the director to be applicable. The application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall demonstrate compliance with the following requirements:

(1) The plan is operating lawfully under the laws of Mexico.

(2) The plan offers and sells in this state only employer-sponsored group plan contracts exclusively for the benefit of citizens of Mexico legally employed in this state, and for the benefit of their dependents regardless of nationality, that pay for, reimburse the cost of, or arrange for the provision or delivery of health care services that are to be provided or delivered wholly in Mexico, except for the provision or delivery of those health care services set forth in subparagraphs (A) and (B) of paragraph (4).

(3) Solicitation of plan contracts in this state is made only through insurance brokers and agents licensed in this state or a third-party administrator licensed in this state, each of which is authorized by the plan to offer and sell plan group contracts.

(4) Group contracts provide, through a contract of insurance between the plan and an insurer admitted in this state, for the reimbursement of emergency and urgent care services provided out of area as required by subdivision (h) of Section 1345.

(5) All advertising, solicitation material, disclosure statements, evidences of coverage, and contracts are in compliance with the appropriate provisions of this chapter and the rules or orders of the director. The director shall require that each of these documents contain a legend in 10-point type, in both English and Spanish, declaring that the health care service plan contract provided by the plan may be limited as to benefits, rights, and remedies under state and federal law.

(6) All funds received by the plan from a subscriber are deposited in an account of a bank organized under the laws of this state or in an account of a national bank located in this state.

(7) The plan maintains a tangible net equity as required by this chapter and the rules of the director, as calculated under United States generally accepted accounting principles, in the amount of a least one million dollars ($1,000,000). In lieu of an amount in excess of the minimum tangible net equity of one million dollars ($1,000,000), the plan may demonstrate a reasonable acceptable alternative reimbursement arrangement that the director may in his or her discretion accept. The plan shall also maintain a fidelity bond and a surety bond as required by Section 1376 and the rules of the director.

(8) The plan agrees to make all of its books and records, including the books and records of health care providers in Mexico, available to the director in the form and at the time and place requested by the director. Books and records shall be made available to the director no later than 24 hours from the date of the request.

(9) The plan files a consent to service of process with the director and agrees to be subject to the laws of this state and the United States in any investigation, examination, dispute, or other matter arising from the advertising, solicitation, or offer and sale of a plan contract, or the management or provision of health care services in this state or throughout the United States. The plan shall agree to notify the director, immediately and in no case later than one business day, if it is subject to any investigation, examination, or administrative or legal action relating to the plan or the operations of the plan initiated by the government of Mexico or the government of any state of Mexico against the plan or any officer, director, security holder, or contractor owning 10 percent or more of the securities of the plan. The plan shall agree that in the event of conflict of laws in any action arising out of the license, the laws of California and the United States shall apply.

(10) The plan agrees that disputes arising from the group contracts involving group contract holders and providers of health care services in the United States shall be subject to the jurisdiction of the courts of this state and the United States.

(b) The plan shall pay the application processing fee and other fees and assessments set forth in Section 1356. The director, by order,

may designate provisions of this chapter and rules adopted thereunder that need not be applied to a health care service plan licensed under the laws of Mexico when consistent with the intent and purpose of this chapter, and in the public interest.

SEC. 54. Section 1352 of the Health and Safety Code is amended to read:

1352. (a) A licensed plan shall, within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment thereto in the manner the director may by rule prescribe setting forth the changed information. However, the addition of any association, partnership, or corporation in a controlling, controlled, or affiliated status relative to the plan shall necessitate filing, within a 30-day period of an authorization for disclosure to the director of financial records of the person pursuant to Section 7473 of the Government Code.

(b) Prior to any material modification of its plan or operations, a plan shall give notice thereof to the director, who shall, within 20 business days or such additional time as the plan may specify, by order approve, disapprove, suspend, or postpone the effectiveness of any such change, subject to Section 1354.

(c) A plan shall, within five days, give written notice to the director in the form as by rule may be prescribed, of any change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the plan and of any management company of the plan, and of any parent company of the plan or management company. The director may by rule define the positions, duties, and relationships which are referred to in this subdivision.

(d) The fee for filing a notice of major modification pursuant to subdivision (b) shall be the actual cost to the director of processing the notice, including overhead, but shall not exceed seven hundred fifty dollars ($750).

SEC. 55. Section 1352.1 of the Health and Safety Code is amended to read:

1352.1. (a) Except as provided in subdivision (b), no plan shall enter into any new or modified plan contract or publish or distribute, or allow to be published or distributed on its behalf, any disclosure form or evidence of coverage, unless (1) a true copy thereof has first been filed with the director, at least 30 days prior to any such use, or any shorter period as the director by rule or order may allow, and (2) the director by notice has not found the plan contract, disclosure form, or evidence of coverage, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this chapter or the rules thereunder, and specified the deficiencies, within at least 30 days or any shorter time as the director by rule or order may allow.

(b) Except as provided in subdivision (c), a licensed plan which has been continuously licensed under this chapter for the preceding 18 months and which has had group contracts in effect at all times during that period may enter a new or modified group contract or may publish or distribute, or allow to be published or distributed on its behalf, any group disclosure form or evidence of coverage without having filed the same for the director's prior approval, if the plan and the materials comply with each of the following conditions:

(1) The contract, disclosure form, or evidence of coverage, or any material provision thereof, has not been previously disapproved by the director by written notice to the plan and the plan reasonably believes that the contract, disclosure form, and evidence of coverage do not violate any requirements of this chapter or the rules thereunder.

(2) The plan files the contract and any related disclosure form and evidence of coverage with the director not later than 10 business days after entering the contract, or within any additional period as the director by rule or order may provide.

(3) If the person or group entering into the contract with the plan is not an employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.), the person or group is not organized solely or principally for the purpose of providing health benefits to members of the group.

(c) The director by order may require a plan which has entered any group contract or published or distributed, or allowed to be published or distributed on its behalf, any disclosure form or evidence of coverage in violation of this chapter or the rules thereunder to comply with subdivision (a) prior to entering group contracts, or a specified class of group contracts, and prior to publishing or distributing, or allowing to be published or distributed on its behalf, related disclosure forms and evidences of coverage. An order issued pursuant to this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the contracts, disclosure forms, or evidences of coverage submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this chapter and the rules thereunder.

(d) A licensed plan or other person regulated under this chapter may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the director.

SEC. 56. Section 1353 of the Health and Safety Code is amended to read:

1353. The director shall issue a license to any person filing an application pursuant to this article, if the director, upon due consideration of the application and of the information obtained in any investigation, including, if necessary, an onsite inspection, determines that the applicant has satisfied the provisions of this

chapter and that, in the judgment of the director, a disciplinary action pursuant to Section 1386 would not be warranted against such applicant. Otherwise, the director shall deny the application.

SEC. 57. Section 1354 of the Health and Safety Code is amended to read:

1354. Upon denial of application for licensure, or the issuance of an order pursuant to Section 1352 disapproving, suspending, or postponing a material modification, the director shall notify the applicant in writing, stating the reason for the denial and that the applicant has the right to a hearing if the applicant makes written request within 30 days after the date of mailing of the notice of denial. Service of the notice required by this subdivision may be made by certified mail addressed to the applicant at the latest address filed by the applicant in writing with the department.

SEC. 58. Section 1355 of the Health and Safety Code is amended to read:

1355. Every plan's license issued under this chapter shall remain in effect until revoked or suspended by the director, except that every transitional license shall expire on September 30, 1978, unless such expiration date is extended by the director.

SEC. 59. Section 1356 of the Health and Safety Code is amended to read:

1356. (a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars ($25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to any applicant prior to receiving payment in full for all amounts charged pursuant to this subdivision.

(b) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial examinations, grievances and complaints including maintaining a toll-free number for consumer grievances and complaints, investigation and enforcement, medical surveys and reports, and overhead, reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year. The amount paid by each plan, except a plan offering only specialized health care service plan contracts, shall be twelve thousand five hundred dollars ($12,500), plus an amount

up to, but not exceeding, an amount computed in accordance with the following schedule:

Plan Enrollment	Amount of Assessment
0 to 25,000	$0 + 65 cents for each enrollee
25,001 to 75,000	$16,250 + 53 cents for each enrollee in excess of 25,000
75,001 to 150,000	$42,750 + 50 cents for each enrollee in excess of 75,000
150,001 to 300,000	$80,250 + 47 cents for each enrollee in excess of 150,000
over 300,000	$150,750 + 45 cents for each enrollee in excess of 300,000

Plans offering only specialized health care service plan contracts shall pay seven thousand five hundred dollars ($7,500), plus an amount up to, but not exceeding, an amount computed in accordance with the following schedule:

Plan Enrollment	Amount of Assessment
0 to 25,000	$0 + 48 cents for each enrollee
25,001 to 75,000	$12,000 + 36 cents for each enrollee in excess of 25,000
75,001 to 150,000	$30,000 + 30 cents for each enrollee in excess of 75,000
150,001 to 300,000	$52,500 + 26 cents for each enrollee in excess of 150,000
over 300,000	$91,500 + 24 cents for each enrollee in excess of 300,000

The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the commissioner determines that the method used for determining the estimate was not reasonable.

In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the support of this chapter and all reimbursements provided for in this chapter.

(c) Each licensed plan shall also pay two thousand dollars ($2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent ($0.0048) for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) The director by notice to all licensed plans on or before September 15, 2000, may require health care service plans to pay an additional assessment to provide the department with sufficient revenues to support the 2000–01 fiscal year costs and expenses as set forth in this section.

SEC. 60. Section 1356.1 of the Health and Safety Code is amended to read:

1356.1. Notwithstanding subdivision (f) of Section 1356, as amended by Section 2.5 of Chapter 722 of the Statutes of 1991, and subdivision (d) of Section 1356, as amended by Section 3 of Chapter 722 of the Statutes of 1991, if the director determines that the charges and assessments set forth in this chapter for any year are in excess of the amount necessary, or are insufficient, to meet the expenses of administration of this chapter, for that year, the assessments and charges for the following year shall be adjusted on a pro rata basis in accordance with the percentage of the excess or insufficiency as related to the actual charges and assessments for the year for which the excess or insufficiency occurred, in order to recover the actual costs of administration.

SEC. 61. Section 1357.03 of the Health and Safety Code is amended to read:

1357.03. (a) Upon the effective date of this article, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to small employers or to associations that include small employers to all small employers in each service area in which the plan provides or arranges for the provision of health care services. A plan contracting to participate in the voluntary purchasing pool for small employers provided for under Article 4 (commencing with Section 10730) of Chapter 14 of Part 2 of Division 2 of the Insurance Code shall be deemed in compliance with this requirement for a contract offered through the voluntary purchasing pool established under Article 4 (commencing with Section 10730) of Chapter 14 of Part 2 of Division 2 of the Insurance Code in those geographic regions in which plans participate in the pool, if the contract is offered exclusively through the pool. Each plan shall make available to each small employer all small employer health care service plan contracts which the plan

offers and sells to small employers or to associations that include small employers in this state. No plan or solicitor shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with the employee's employment or membership in a guaranteed association.

(b) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (a) of Section 1357 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage under subdivision (o) of Section 1357 but not electing any health coverage through the association shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

(c) The plan may not reject an application from a small employer for a health care service plan contract if all of the following are met:

(1) The small employer, as defined by paragraph (1) of subdivision (*l*) of Section 1357 offers health benefits to 100 percent of its eligible employees, as defined by paragraph (1) of subdivision (b) of Section 1357. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(3) The small employer agrees to inform the small employers' employees of the availability of coverage and the provision that those not electing coverage must wait one year to obtain coverage through the group if they later decide they would like to have coverage.

(4) The employees and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(d) No plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(2) Encourage or direct small employers to seek coverage from another plan or the voluntary purchasing pool established under Article 4 (commencing with Section 10730) of Chapter 14 of Part 2 of Division 2 of the Insurance Code because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(e) No plan shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(f) No policy or contract that covers two or more employees may establish rules for eligibility, including continued eligibility, of any individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors: (1) health status, (2) medical condition, including physical and mental illnesses, (3) claims experience, (4) receipt of health care, (5) medical history, (6) genetic information, (7) evidence of insurability, including conditions arising out of acts of domestic violence, or (8) disability.

(g) Each plan shall comply with the requirements of Section 1374.3.

SEC. 62. Section 1357.09 of the Health and Safety Code is amended to read:

1357.09. No plan shall be required to offer a health care service plan contract or accept applications for such a contract pursuant to this article in the case of any of the following:

(a) To a small employer, where the small employer is not physically located in a plan's approved service areas, or where an eligible employee and dependents who are to be covered by the plan contract do not work or reside within a plan's approved service areas.

(b) Within a specific service area or portion of a service area where a plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to assure that health care services will be available

and accessible to the eligible employee and dependents of the employee because of its obligations to existing enrollees.

(1) A plan that cannot offer a health care service plan contract to small employers because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the plan is not offering coverage to small employers to new employer groups with more than 50 eligible employees until the plan notifies the director that it has the ability to deliver services to small employer groups, and certifies to the director that from the date of the notice it will enroll all small employer groups requesting coverage in that area from the plan unless the plan has met the requirements of subdivision (d).

(2) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity have become impaired.

(c) Offer coverage to a small employer or an eligible employee as defined under paragraph (2) of subdivision (b) of Section 1357 which, within 12 months of application for coverage, disenrolled from a plan contract offered by the plan.

(d) The director approves the plan's certification that the number of eligible employees and dependents enrolled under contracts issued during the current calendar year equals or exceeds (1) in the case of a plan that administers any self-funded health coverage arrangements in California, 10 percent of the total enrollment of the plan in California as of December 31 of the preceding year, or (2) in the case of a plan that does not administer any self-funded health coverage arrangements in California, 8 percent of the total enrollment of the plan in California as of December 31 of the preceding year. If that certification is approved, the plan shall not offer any health care service plan contract to any small employers during the remainder of the current year.

(1) If a health care service plan treats an affiliate or subsidiary as a separate carrier for the purpose of this article because one health care service plan is qualified under the federal Health Maintenance Organization Act and does not offer coverage to small employers, while the affiliate or subsidiary offers a plan contract that is not qualified under the federal Health Maintenance Organization Act and offers plan contracts to small employers, the health care service plan offering coverage to small employers shall enroll new eligible employees and dependents, equal to the applicable percentage of the total enrollment of both the health care service plan qualified under the federal Health Maintenance Organization Act and its affiliate or subsidiary.

(2) The certified statement filed pursuant to this subdivision shall state the following:

(A) Whether the plan administers any self-funded health coverage arrangements in California.

(B) The plan's total enrollment as of December 31 of the preceding year.

(C) The number of eligible employees and dependents enrolled under contracts issued to small employer groups during the current calendar year.

The director shall, within 45 days, approve or disapprove the certified statement. If the certified statement is disapproved, the plan shall continue to issue coverage as required by Section 1357.03 and be subject to disciplinary action as set forth in Article 7 (commencing with Section 1386).

(e) A health care service plan that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and 50 percent or more of the plan's total enrollment have premiums paid by the Medi-Cal program.

(f) A social health maintenance organization, as described in subdivision (a) of Section 2355 of the federal Deficit Reduction Act of 1984 (Public Law 97-369), that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and has 50 percent or more of the organization's total enrollment premiums paid by the Medi-Cal program or Medicare programs, or by a combination of Medi-Cal and Medicare. In no event shall this exemption be based upon enrollment in Medicare supplement contracts, as described in Article 3.5 (commencing with Section 1358).

SEC. 63. Section 1357.10 of the Health and Safety Code is amended to read:

1357.10. The director may require a plan to discontinue the offering of contracts or acceptance of applications from any small employer or group with more than 50 employees upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to assure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

SEC. 64. Section 1357.11 of the Health and Safety Code is amended to read:

1357.11. All health care service plan contracts offered to a small employer shall be renewable with respect to all eligible employees or dependents at the option of the contractholder or small employer except:

(a) For nonpayment of the required premiums by the contractholder or small employer.

(b) For fraud or misrepresentation by the contractholder or small employer or, with respect to coverage of individuals, the individuals or their representatives.

(c) For noncompliance with a plan's participation or employer contribution requirements at the time of renewal.

(d) When the plan ceases to provide or arrange for the provision of health care services for new small employer health care service plan contracts in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing small employer health benefits plans in this state is provided to the director and to either the contractholder or small employer at least 180 days prior to the discontinuation of the coverage.

(2) Small employer health care service plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan which remains in force, any plan that ceases to offer for sale new small employer health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.

(3) Except as authorized under subdivision (d) of Section 1357.09 and Section 1357.10, a plan that ceases to write new small employer business in this state after the effective date of this article shall be prohibited from offering for sale new small employer health care service plan contracts in this state for a period of five years from the date of notice to the director.

(e) When the plan withdraws a health care service plan contract from the small employer market; provided, the plan notifies all affected contractholders or small employers and the director at least 90 days prior to the discontinuation of those contracts, and the plan makes available to the small employer all plan contracts that it makes available to new small employer business; and provided, that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.12.

SEC. 65. Section 1357.15 of the Health and Safety Code is amended to read:

1357.15. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article which will be in force on the operative date of this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. The certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the director, as permitted under Section

1352, to disapprove, suspend or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(b) At least 20 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. The certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Plans that will be offering to a small employer plan contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(c) Prior to making any changes in the risk categories, risk adjustment factors or standard employee risk rates filed with the director pursuant to subdivision (a) or (b), the plan shall file as an amendment a statement setting forth the changes and certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. A plan may commence offering plan contracts utilizing the changed risk categories set forth in the certified statement on the 31st day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the reasons therefor. If only the standard employee risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence offering plan contracts utilizing the changed standard employee risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.

(d) Periodic changes to the standard employee risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).

(e) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.

(f) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular small employer.

(g) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.

SEC. 66. Section 1357.16 of the Health and Safety Code is amended to read:

1357.16. (a) Health care service plans may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Health care service plans that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The health care service plan shall permit all qualified associations to assume one or more of these functions when the health care service plan determines the qualified association demonstrates the administrative capacity to assume these functions.

For the purposes of this section, administrative services provided by qualified associations or their third-party administrators shall be services pertaining to eligibility determination, enrollment, premium collection, sales, or claims administration on a per-claim basis that would otherwise be provided directly by the health care service plan or through a third-party administrator on a commission basis or an agent or solicitor work force on a commission basis.

Each health care service plan that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service plan shall apply these uniform discounts to the health care service plan’s risk adjusted employee risk rates after the health plan has determined the qualified association’s risk adjusted employee risk rates pursuant to Section 1357.12. The health care service plan shall report to the Department of Managed Care its schedule of discount for each administrative service.

In no instance may a health care service plan provide discounts to qualified associations that are in any way intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association. In addition to any other remedies available to the director to enforce this chapter, the director may declare a contract between a health care service plan and a qualified association for administrative services pursuant to this section null and void if the director determines any discounts provided to the qualified association are intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association.

(b) For the purposes of this section, a qualified association is a nonprofit corporation comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, that conforms to all of the following requirements:

(1) It accepts for membership any individual or small employer meeting its membership criteria.

(2) It does not condition membership directly or indirectly on the health or claims history of any person.

(3) It uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.

(4) It is organized and maintained in good faith for purposes unrelated to insurance.

(5) It existed on January 1, 1972, and has been in continuous existence since that date.

(6) It has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.

(7) It offered, marketed, or sold health coverage to its members for 20 continuous years prior to January 1, 1993.

(8) It agrees to offer only to association members any plan contract.

(9) It agrees to include any member choosing to enroll in the plan contract offered by the association, provided that the member agrees to make required premium payments.

(10) It complies with all provisions of this article.

(11) It had at least 10,000 enrollees covered by association sponsored plans immediately prior to enactment of Chapter 1128 of the Statutes of 1992.

(12) It applies any administrative cost at an equal rate to all members purchasing coverage through the qualified association.

(c) A qualified association shall comply with Section 1357.52.

(d) The department shall monitor compliance with this section and report the impact of any noncompliance to the Assembly Insurance Committee and the Senate Insurance Committee on January 1, 2002.

(e) This section shall remain in effect only until January 1, 2003, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2003, deletes or extends that date.

SEC. 67. Section 1357.17 of the Health and Safety Code is amended to read:

1357.17. The director may issue regulations that are necessary to carry out the purposes of this article. Prior to the public comment period required on the regulations under the Administrative Procedure Act, the director shall provide the Insurance

Commissioner with a copy of the proposed regulations. The Insurance Commissioner shall have 30 days to notify the director in writing of any comments on the regulations. The Insurance Commissioner's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until December 31, 1994, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety or general welfare.

SEC. 68. Section 1357.53 of the Health and Safety Code is amended to read:

1357.53. All group health benefit plans shall be renewable with respect to the contractholder or employer except as follows:

(a) For nonpayment of the required premiums by the contractholder or employer.

(b) For fraud or other intentional misrepresentation of material fact by the contractholder or employer.

(c) For noncompliance with a material plan contract provision.

(d) If the plan ceases to provide or arrange for the provision of health care services for new health benefit plans in the state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing group health benefit plans in the state shall be provided to the director and to either the contractholder or employer at least 180 days prior to discontinuation of this coverage.

(2) Group health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any plan that ceases to offer for sale new group health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) Except as authorized under subdivision (d) of Section 1357.09 and Section 1357.10, a plan that ceases to write new group health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale group health benefit plans in this state for a period of five years from the date of notice to the director.

(e) If the plan withdraws a group health benefit plan from the market; provided, that the plan notifies all affected contractholders or employers and the director at least 90 days prior to the discontinuation of these plans, and that the plan makes available to the employer all health benefit plans that it makes available to new employer business without regard to the claims experience or health-related factors of enrollees.

SEC. 69. Section 1357.54 of the Health and Safety Code is amended to read:

1357.54. All individual health benefit plans, except for short-term limited duration insurance, shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) For nonpayment of the required premiums or contributions by the individual in accordance with the terms of the health insurance coverage or the timeliness of the payments.

(b) For fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual.

(c) Movement of the individual contractholder outside the service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) If the plan ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in the state is provided to the director and to the individual at least 180 days prior to discontinuation of that coverage.

(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any plan that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) A plan that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the director.

(e) If the plan withdraws an individual health benefit plan from the market; provided, that the plan notifies all affected individuals and the director at least 90 days prior to the discontinuation of these plans, and that the plan makes available to the individual all health benefit plans that it makes available to new individual business without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

SEC. 70. Section 1358 of the Health and Safety Code is amended to read:

1358. Every health care service plan that offers any contract that primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, shall, in addition to complying with this chapter and rules of the director, comply with this article. This article shall not apply to a contract or other arrangement of a health care service plan that offers benefits under Section 1395mm of Title 42 of the United States Code or under a demonstration project authorized pursuant to amendments to the federal Social Security Act. This article shall not apply to a contract of one or more employers or labor organizations, or of the trustees of

a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

As used in this chapter, ''Medicare'' means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, Title 1, Part 1 of Public Law 89-97, enacted by the 89th United States Congress; as then constituted or as later amended.

SEC. 71. Section 1358.1 of the Health and Safety Code is amended to read:

1358.1. A plan offering contracts to supplement Medicare shall do all of the following:

(a) Meet the minimum benefit standards as established by the director.

(b) Provide an examination period of 30 days after the receipt of the contract for purposes of review of the contract at which time the applicant may return the contract. The return shall void the contract from the beginning, and the parties shall be in the same position as if no policy or contract had been issued. All premiums paid and any policy fee paid for the policy shall be fully refunded to the owner by the plan in a timely manner.

(1) Each plan contract or certificate shall have a notice prominently printed in no less than 10-point upper case type, on the cover page of the plan contract or certificate or attached thereto, and on the cover page of the outline of coverage, stating that the applicant has the right to return the plan contract or certificate within 30 days after its receipt via regular mail, and to have the full premium refunded.

(2) For purposes of this section, a timely manner shall be no later than 30 days after the plan or entity issuing the contract or certificate receives the returned contract or certificate.

(3) If the plan or entity issuing the contract or certificate fails to refund all premiums paid in a timely manner, then the applicant shall receive interest on the paid premium at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the plan or entity received the returned contract or certificate.

(c) Explain the relationship of the coverage under the contract to the benefits provided by Medicare.

(d) Not be limited to coverage exclusively for a single disease or affliction.

(e) If the plan contract or policy does not cover custodial care, the cover page of the outline of coverages required by subdivision (c) shall contain the following statement in upper case type: ''THIS POLICY DOES NOT COVER CUSTODIAL CARE IN A SKILLED NURSING CARE FACILITY.''

SEC. 72. Section 1358.2 of the Health and Safety Code is amended to read:

1358.2. (a) The disclosure form required pursuant to Section 1363 and applicable regulations, if it relates to a contract that primarily or solely supplements Medicare, with hospital or medical coverage shall also set forth the following information in the format indicated:

(1) With the information required by paragraph (1) of subdivision (b) of Section 1300.63 of Title 10 of the California Code of Regulations, conspicuously identify, on the first page of the disclosure form immediately under the plan name, the disclosure form as being for the plan's Medicare supplement contract.

(2) If the Medicare supplement contract is issued on a basis not identical to that described in the disclosure form previously provided, a corrected disclosure form shall also be provided in accordance with Section 1363 when the contract is delivered and shall contain the following statement, in no less than 12-point type on the first page, immediately above the company name:

''NOTICE: Read this disclosure form carefully. It is not identical to the disclosure form previously provided and the coverage originally applied for has not been issued.''

(3) The outline of coverage provided to applicants pursuant to this section shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the plan.

The cover page shall include the items, in the same order, specified in the chart set forth in paragraph (4) of subdivision (C) of Section 16 of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners on July 30, 1991. All benefit plans ''A'' through ''J'' shall be shown on the cover page, and the plan or plans that are offered by the plan shall be prominently identified.

All possible charges for benefit plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. All possible charges shall be stated for all benefit plans that are offered to the prospective applicant. All possible charges for the prospective applicant shall be illustrated.

The disclosure pages shall be in the language and format described below in no less than 12-point type.

PREMIUM INFORMATION

[Insert plan's name] can only raise your premium if it raises the premium for all contracts like yours in this state. [If the premium is

based on the increasing age of the enrollee, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing the most important features of your Medicare supplement plan contract. This is not the plan contract and only the actual contract provisions will control. You must read the contract itself to understand all of the rights and duties of both you and [insert the health care service plan's name].

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your contract, you may return it to [insert plan's address]. If you send the contract back to us within 30 days after you receive it, we will treat the contract as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing other health coverage, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs. Neither [insert the health care service plan's name] nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult ''The Medicare Handbook'' for further details and limitations applicable to Medicare.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information. [If the contract is guaranteed issue, this paragraph need not appear.] Review the application carefully before you sign it. Be certain that all information has been properly recorded. [The charts

displaying the features of each benefit plan offered by the plan shall use the uniform format and language shown in the charts set forth in Section 16 of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners on July 30, 1991. No more than four benefit plans may be shown on one chart. For purposes of illustration, charts for each benefit plan are set forth below. A plan may use additional benefit plan designations on these charts.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

(b) Notwithstanding Section 1300.63.2 of Title 10 of the California Code of Regulations, no plan shall combine the evidence of coverage and disclosure form into a single document relating to a contract that supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage.

(c) Notwithstanding this section, a plan shall not be required to comply with this section with respect to any group contract that is any of the following:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or combination thereof or for members or former members, or combination thereof, of the labor organizations.

(2) A group contract with any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of the contract to its members.

SEC. 73. Section 1358.4 of the Health and Safety Code is amended to read:

1358.4. (a) In the interest of full and fair disclosure, and to assure the availability of necessary consumer information to potential subscribers or enrollees not possessing a special knowledge of Medicare, health care service plans, and Medicare supplement contracts, a health care service plan offering contracts to supplement Medicare shall comply with the provisions of subdivision (b).

(b) The application form or other consumer information for persons eligible for Medicare and used by a plan described in subdivision (a) shall contain as an attachment a Medicare supplement buyer’s guide in the form approved by the director. The application or other consumer information, containing as an attachment the buyer’s guide, shall be mailed or delivered to each

person applying for that coverage at or before the time of application and, to establish compliance with this subdivision, the plan shall obtain an acknowledgment of receipt of the attached buyer's guide from each applicant. No plan shall make use of or otherwise disseminate any buyer's guide that does not accurately outline current Medicare benefits. No plan shall be required to provide more than one copy of the buyer's guide to any applicant.

(c) A plan may comply with the requirement of this section in the case of group contracts by causing the group contractholder (1) to disseminate copies of the disclosure form containing as an attachment the buyer's guide to all persons eligible under the group contract at the time those persons are offered the plan, and (2) collecting and forwarding to the plan an acknowledgment of receipt of the disclosure form containing as an attachment the buyer's guide from each person described in paragraph (1).

(d) Notwithstanding the provisions of this section, a plan shall not be required to comply with the provisions of this section with respect to any group contract that is any of the following:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees, or former employees or combination thereof, or for members or former members, or combination thereof, of the labor organizations.

(2) A group contract with any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of the contract to its members.

SEC. 74. Section 1358.6 of the Health and Safety Code is amended to read:

1358.6. (a) On or before March 1 of each year, a health care service plan offering contracts to supplement Medicare, shall report to the director the following information for every individual resident of this state for which the plan has in force more than one Medicare supplement contract:

(1) Contract name.

(2) Date of Issuance.

(b) The items set forth above shall be grouped by enrollee.

SEC. 75. Section 1358.9 of the Health and Safety Code is amended to read:

1358.9. (a) A contract offered to supplement Medicare shall be deemed not to be fair, just, or consistent with the objectives of the Knox-Keene Health Care Service Plan Act of 1975 at all times, and

shall not be advertised, solicited for, entered, or renewed at any time, except during that period of time, if any, beginning with the date of receipt by the plan of notification by the director that the provisions of the contract are deemed to be fair, just, and consistent with the objectives of this chapter, and ending with the earlier to occur of the events indicated in subdivision (b).

(b) The period of time indicated in subdivision (a) shall terminate at the earlier to occur of (1) receipt by the plan of written revocation by the director of the immediate past notification referred to in subdivision (a) specifying the basis for the revocation, (2) the last day of the prepaid or periodic charge calculation period, that in no event may exceed one year, or (3) June 30, of the next succeeding calendar year.

(c) A plan shall secure the director's review of a plan contract subject to this article by submitting, not less than 30 days prior to any proposed advertising or other use of the plan contract not already protected by a currently effective notice under subdivision (a), the following for the director's review:

(1) A copy of the plan contract.

(2) A copy of the disclosure form.

(3) A representation that the plan contract complies with the provisions of this chapter and the rules adopted thereunder.

(4) A completed copy of the ''Medicare Supplement Health Care Service Plan Contract Experience Exhibit'' set forth in Section 1358.17.

(5) A copy of the calculations for the actual or expected loss ratio.

(6) Supporting data used in calculating the actual or expected loss ratio as indicated in Section 1358.11.

(7) An actuarial certification, as specified in Section 1358.11 of the loss ratio computations.

(8) If required by the director, actuarial certification, as specified in Section 1358.11, of the loss ratio computations by one or more unaffiliated actuaries acceptable to the director.

(9) An undertaking by the plan to notify the subscribers in writing within 60 days of decertification, if the contract is identified as a certified contract at the time of sale and later decertified.

(10) A signed statement of the president of the plan or other officer of the plan designated by that person attesting that the information submitted for review is accurate and complete and does not misrepresent any material fact.

(d) A plan that submits information pursuant to subdivision (c) shall provide such additional information as may be requested by the director to enable the director to conclude that the plan contract complies with the provisions of this chapter and rules adopted thereunder.

(e) For the purposes of this section, the term ''decertified,'' as applied to a plan contract, means that the director by written notice

has found that the contract no longer complies with the provisions of this chapter and the rules adopted thereunder and has revoked the prior authorization to display on the plan contract the emblem indicating certification.

(f) Notwithstanding the other provisions of the section, this section shall not apply to any group contract that is all of the following:

(1) A group contract with one or more employers or labor organizations, or of the trustee of a fund established by one or more employers or labor organizations, or combination thereof, for employees, or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organization.

(2) A group contract with any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of the contract to its members.

SEC. 76. Section 1358.10 of the Health and Safety Code is amended to read:

1358.10. (a) No plan subject to this article may advertise, solicit for, enter, or renew any plan contract that primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage if the contract contains any of the prohibited provisions described in subdivision (b), does not contain any of the mandatory provisions described in subdivision (c), or does not conform to the requirements set forth in subdivision (d). No plan contract that primarily or solely supplements Medicare shall contain benefits that duplicate benefits provided by Medicare.

(b) The following provisions shall be deemed to be unfair, unreasonable, and inconsistent with the objectives of this chapter and shall not be contained in any plan contract subject to subdivision (a):

(1) Any waiver, exclusion, limitation, or reduction based on or relating to a preexisting disease or physical condition, unless that waiver, exclusion, limitation, or reduction (A) applies only to coverage for specified services rendered not more than six months from the effective date of coverage, (B) is based on or relates only to a preexisting disease or physical condition defined no more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage, (C) does not apply to any coverage under any group contract, and (D) is approved in advance by the director. Any limitations with respect to a preexisting

condition shall appear as a separate paragraph of the contract and be labeled ''Preexisting Condition Limitations.''

(2) Any provision delaying the effective date of coverage beyond the first day of the month following the date of receipt by the plan of the applicant's properly completed application, except that the effective date of coverage may be delayed until the 65th birthday of an applicant who is to become eligible for Medicare by reason of age if the application is received any time during the three months immediately preceding the applicant's 65th birthday.

(3) Any distinction in coverage based on whether health care services are provided because of illness or injury.

(4) The terms ''Medicare supplement,'' ''Medicare Wrap-Around,'' or terms of similar import to characterize a plan contract, unless the contract is in compliance with the provisions of this chapter and this article. The term ''medigap,'' shall not be used.

(5) Any provision allowing termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the subscriber, other than the nonpayment of the prepaid or periodic charge.

(6) Except with respect to a group contract subject to and in compliance with Section 1399.62, any provision denying coverage, after termination of the contract, for services provided continuously beginning while the contract was in effect, during the continuous total disability of the subscriber or enrollee, except that the coverage may be limited to a reasonable period of time not less than the duration of the contract benefit period, if any, and may be limited to the maximum benefits provided under the contract.

(7) Any definition, condition, limitation, exclusion, reduction, or other provision that is inconsistent with or more restrictive or limiting than that term as officially used in Medicare, except as expressly authorized in this chapter.

(c) A plan contract shall be deemed to be unfair, unreasonable, and inconsistent with the objectives of this chapter and shall not be advertised, solicited for, entered, or renewed unless it contains the following mandatory provisions:

(1) Prominently printed on the first page of the contract, a notice stating in substance that the subscriber or enrollee shall have the right to return the contract within 30 days of its delivery and to have the prepaid or periodic charge refunded if, after examination of the contract, the covered person is not satisfied for any reason.

(2) Appropriately captioned, and appearing on the first page of the contract, a provision regarding renewal or continuation. The provision shall be consistent with subdivision (a) of Section 1365 and the rules adopted thereunder and shall include any reservation by the plan of the right to change prepaid or periodic charges and any automatic renewal increases based on the enrollee's age.

(3) Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and the amount of prepaid charges may be modified, as indicated in paragraph (6) of subdivision (a) of Section 1300.67.4 of the California Code of Regulations, to correspond with those changes.

(4) The health care service plan shall not in any way reduce or eliminate any benefit or coverage under a Medicare supplement contract at any time after the date of entering the contract, including dates of reinstatement or renewal, unless and until the change is voluntarily agreed to in writing signed by the subscriber or enrollee, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits. The health care service plan shall not increase benefits or coverage with a concomitant increase in prepaid or periodic charges during the term of the contract unless and until the change is voluntarily agreed to in writing signed by the subscriber or enrollee or unless the increased benefits or coverage is required by law or regulation.

(5) A plan contract shall not provide for the payment of benefits based on standards described as ''usual and customary,'' ''reasonable and customary,'' or words of similar import.

(6) The plan contract shall contain the provisions required to be set forth in the plan contract by Section 1300.67.4 of the California Code of Regulations.

(d) A plan contract subject to subdivision (a) shall be deemed to be unfair, unreasonable, and inconsistent with the objectives of this chapter and shall not be advertised, solicited for, entered, or renewed unless the contract contains definitions of terms in compliance with the following requirements:

(1) ''Accident,'' ''accidental injury,'' or ''accidental means,'' if defined, shall be defined without including words that establish an accidental means test or use words such as ''external, violent, visible wounds'' or similar words of description or characterization. The definition shall not be more restrictive than the following: ''Injury or injuries for which benefits are provided,'' means accidental bodily injury sustained by the covered person.

(2) ''Benefit period'' or ''Medicare benefit period'' shall not be defined more restrictively than as defined in the Medicare program.

(3) ''Convalescent nursing home,'' ''extended care facility,'' or ''skilled nursing facility'' shall not be defined more restrictively than as defined in the federal Medicare program.

(4) ''Health care expenses'' may include expenses associated with the delivery of health care services, but shall not include (A) home office and overhead costs, (B) advertising costs, (C) commissions and other acquisition costs, (D) taxes, (E) capital costs, (F) administrative costs, or (G) claims processing costs.

(5) ''Hospital'' may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals but not more restrictively than as defined in the federal Medicare program.

(6) ''Medicare'' shall be defined in the contract. Medicare may be substantially defined as ''The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended,'' or ''Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,'' or words of similar import.

(7) ''Medicare eligible expenses'' shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

(8) ''Physician'' shall not be defined more restrictively than as defined in the federal Medicare program.

(9) ''Sickness,'' if defined, shall not be defined to be more restrictive than the following: ''Sickness means illness or disease of a covered person.''

(e) Nothing in this section shall be construed as prohibiting any plan contract, by definitions or express provisions, from limiting or restricting any or all of the benefits provided under the contract, except in-area and out-of-area emergency services, to those health care services that are delivered by plan employed, owned, or contracting providers and provider facilities, so long as the plan contract complies with the provisions of Sections 1367 and 1358.11 and with Section 1300.67 of the California Code of Regulations.

(f) Nothing in this section shall be construed as prohibiting any plan contract that limits or restricts any or all of the benefits provided under the contract in the manner contemplated in subdivision (e) from limiting its obligation to deliver services, and disclaiming any liability from any delay or failure to provide those services (1) in the event of a major disaster or epidemic or (2) in the event of circumstances not reasonably within the control of the plan, such as the partial or total destruction of facilities, war, riot, civil insurrection, disability of a significant part of its health personnel, or similar circumstances so long as the provisions comply with the provisions of subdivision (h) of Section 1367.

SEC. 77. Section 1358.11 of the Health and Safety Code is amended to read:

1358.11. (a) No plan subject to this article may advertise, solicit for, enter, or renew any plan contract that primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage unless the contract returns to the subscribers and enrollees in the form of aggregate benefits under the contract, not including anticipated

refunds or credits, as estimated for the entire period for which prepaid or periodic charges are computed to provide coverage, on the basis of incurred claims or costs of health care services experience and earned prepaid or periodic charges for that period and in accordance with accepted actuarial principles and practices:

(1) At least 75 percent of the aggregate amount of prepaid or periodic charges collected in the case of group contracts.

(2) At least 65 percent of the aggregate amount of prepaid or periodic charges collected in the case of individual contracts.

(b) The calculation of actual or expected loss ratios shall be pursuant to that formula, definitions, procedures, and other provisions as may be deemed by the director, with due consideration of the circumstances of the particular plan, to be fair, reasonable, and consistent with the objectives of this chapter. These loss ratios shall also apply to prestandardized plan contracts and certificates issued prior to July 21, 1992, the date mandated for standardized Medicare supplement coverage by the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508).

(c) Each plan subject to subdivision (a) shall submit to the department a copy of the calculations for the actual or expected loss ratio as required by Section 1358.9. The calculations shall include the following data: the actual loss ratio for the entire period in which the plan contract has been in force, as well as for the immediate past three years and for each year in which the plan contract has been in force; the scale of prepaid or periodic charges for the loss ratio calculation period, a description of all assumptions, the formula used to calculate gross prepaid or periodic charges, the expected level of earned prepaid or periodic charges in the loss ratio calculation period, and the expected level of incurred claims for reimbursement, including paid claims and incurred but not paid claims, in the loss ratio calculation period. The calculations shall be accompanied by an actuarial certification, consisting of a signed declaration of an actuary who is a member in good standing of the American Academy of Actuaries in which the actuary states that the assumptions used in calculating the expected loss ratio are appropriate and reasonable, taking into account that the calculations are in accordance with the provisions of subdivision (b) and the provisions referred to therein. In addition, the director may require the plan to submit actuarial certification, as described above, by one or more unaffiliated actuaries acceptable to the director.

(d) Notwithstanding the calculations required by subdivision (c), plan contracts shall be deemed to comply with the loss ratio standards if, and shall be deemed not to comply with the loss standards unless: (1) for the most recent year, the ratio of the incurred losses to earned prepaid charges for contracts that have been in force for three years or more is greater than or equal to the applicable percentages contained in this section; and (2) the expected losses in relation to

premiums over the entire period for which the contract is rated comply with the requirements of this section. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for contracts in force less than three years.

(e) Notwithstanding the provisions of this section, this section shall not apply to any group contract that is either:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or organizations, or combination thereof, for employees or former employees or combination thereof or for members or former members, or combination thereof, of the labor organizations.

(2) A group contract with any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of the contract to its members.

(f) For contracts issued prior to July 21, 1992, expected claims in relation to premiums shall meet all of the following:

(1) The originally filed anticipated loss ratio when combined with the actual experience since July 21, 1992.

(2) The appropriate percentage from paragraphs (1) and (2) of subdivision (a) when combined with actual expenses on or after the effective date of this act.

(3) The appropriate percentage from paragraphs (1) and (2) of subdivision (a) over the entire future period for which rates are computed to provide coverage on or after the effective date of this act.

SEC. 78. Section 1358.12 of the Health and Safety Code is amended to read:

1358.12. (a) To comply with federal law (P.L. 101-508, Section 4351) a plan shall, for each Medicare supplement contract it offers, collect and file with the director by May 31, of each year the data contained in the reporting form contained in Appendix A of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners on July 30, 1991.

(b) If on the basis of the experience as reported the bench mark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each Medicare supplement contract offered by the plan. For purposes of the refund or credit calculation, experience on contracts issued within the reporting year shall be excluded.

(c) A refund or credit shall be made only when the bench mark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds ten dollars ($10). The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury Notes. A refund or credit against prepaid or periodic charges due shall be made by September 30 following the experience year upon which the refund or credit is based.

(d) The director may conduct a public hearing to gather information if the experience of the form filed under subdivision (a) for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

SEC. 79. Section 1358.14 of the Health and Safety Code is amended to read:

1358.14. (a) Every plan shall, by June 30 of each year, file with the director a list of its Medicare supplement plan contracts offered or issued or outstanding in this state as of the end of the previous calendar year.

(b) The list shall identify the filing plan by name and address, shall identify each type of contract it offers by name and form number, if one is used, and shall differentiate between contracts filed with and approved by the director in years prior to the previous calendar year, and those filed and approved in the previous calendar year.

(c) The list shall specifically identify all of the following:

(1) Contracts that are issued and outstanding in this state but are no longer offered for sale.

(2) Contracts that, for any reason, were not filed and approved by the director.

(3) Contracts for which the director’s approval was withdrawn within the previous calendar year.

(d) The director shall, on or before the first day of September of each year provide the Secretary of Health and Human Services with a list identifying each plan contract by name and address and the information required to be submitted by this section.

SEC. 80. Section 1358.15 of the Health and Safety Code is amended to read:

1358.15. (a) Within 30 days prior to the effective date of any Medicare benefit changes, a plan providing Medicare supplement contracts to a resident of this state shall file with the director, and notify its contract holders of, modifications it has made to Medicare supplement contracts.

(1) The notice shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement contract.

(2) The notice shall inform each subscriber and enrollee as to when any adjustment in the prepaid or periodic charges will be made due to changes in Medicare benefits.

(3) The notice of benefit modifications and any adjustments to the prepaid or periodic charges shall be in outline form and in clear and simple terms so as to facilitate comprehension. The notice shall not contain or be accompanied by any solicitation.

(b) No modifications to existing Medicare supplement coverage shall be made at the time of, or in connection with the notice requirements of this regulation except to the extent necessary to eliminate duplication of Medicare benefits and any modifications necessary under the contract to provide indexed benefit adjustment.

(c) As soon as practicable, but prior to the effective date of changes in Medicare benefits a plan providing Medicare supplement contracts in this state shall file the following with the director:

(1) Appropriate prepaid or periodic charge adjustments necessary to produce loss ratios as anticipated for the current prepaid or periodic charges for the applicable contracts. Those supporting documents as are necessary to justify the adjustment shall accompany the filing.

(2) Any appropriate contract amendments needed to accomplish the Medicare supplement coverage modifications necessary to eliminate benefit duplications with Medicare. Any such contract amendments shall provide a clear description of the Medicare supplement benefits provided by the contract.

(d) Upon satisfying the filing and approval requirements of the director, a plan providing Medicare supplement coverage in this state shall provide each subscriber or enrollee with any contract amendment necessary to eliminate any benefit duplications under the contract with benefits provided by Medicare.

(e) Every plan providing Medicare supplement coverage to a resident of this state shall make those prepaid or periodic charge adjustments as are necessary to produce an expected loss ratio under the contract as will conform with minimum loss ratio standards for Medicare supplement contracts and that is expected to result in a loss ratio at least as great as that originally anticipated. No prepaid or periodic charge adjustment that would modify loss ratio experience, other than the adjustments described herein, shall be made at any time other than upon the renewal date.

SEC. 81. Section 1358.16 of the Health and Safety Code is amended to read:

1358.16. (a) A plan offering Medicare supplement coverage shall, as a condition precedent to the director’s approval or continued approval of Medicare supplement contracts offered in this state,

agree to accept and shall accept a notice under Section 1842(h)(3)(B) of the Social Security Act (42 U.S.C. Sec. 1395u(h)(3)(B)) as a claim form for benefits under those contracts in lieu of any claim form otherwise required, and shall agree to make a payment determination and shall make that determination on the basis of the information contained in or accompanying the notice.

(b) As further conditions precedent to the approval or continued approval of Medicare supplement contracts, a plan offering Medicare supplement coverage in this state shall do all of the following:

(1) When a notice under Section 1842(h)(3)(B) of the Social Security Act (42 U.S.C. Sec. 1395u(h)(3)(B)) is received:

(A) Provide written notice of the payment determination to the participating physician or supplier and assignor.

(B) Provide any payment due directly to the participating physician or supplier involved.

(2) Provide each subscriber and enrollee at the time coverage is initiated, a card listing the contract name and number and a single mailing address to which notices under Section 1842(h)(3)(B) of the Social Security Act (42 U.S.C. Sec. 1395u(h)(3)(B)) respecting coverage are to be sent.

(3) Pay any user fees established under Section 1842(h)(3)(B) of the Social Security Act (42 1395u(h)(3)(B)).

(4) Provide the Secretary of Health and Human Services at least annually, a single mailing address to which notices under Section 1842(h)(3)(B) (42 U.S.C. Sec. 1395u(h)(3)(B)) are to be sent.

SEC. 82. Section 1358.18 of the Health and Safety Code is amended to read:

1358.18. In compliance with the Medicare supplement coverage standardization requirements of Section 1882 of the Social Security Act (42 U.S.C.A. Sec. 1395ss), as added by the Omnibus Reconciliation Act of 1990 (P.L. 101-508), the following standards are applicable to all Medicare supplement contracts subject to this article delivered or issued for delivery on or after the effective date of this section. No contract may be advertised, solicited, offered, or issued for delivery in this state as a Medicare supplement contract unless it complies with these benefit standards, as well as all other requirements under this chapter. The basic health care services required to be provided pursuant to Sections 1345 and 1367 of this chapter shall not be included in Medicare supplement contracts subject to this article, to the extent that California is required to disallow coverage for these health care services under the federal Medicare supplement standardization requirements set forth in Section 1882 of the Social Security Act (42 U.S.C.A. 1395ss).

(a) (1) All Medicare supplement contracts shall be guaranteed renewable. A plan shall not cancel or nonrenew a contract solely on the ground of the health status of the individual. A plan shall not

cancel or nonrenew a contract for any reason other than nonpayment of the prepaid or periodic charge or misrepresentation of the risk by the applicant that is shown by the plan to be material to the acceptance for coverage. The contestability period for Medicare supplement contracts shall be two years.

(2) Termination of a Medicare supplement contract shall be without prejudice to any continuous loss that commenced while the contract was in force, but the extension of benefits beyond the period during which the contract was in force may be conditioned upon the continuous total disability of the subscriber or enrollee, limited to the duration of the contract benefit period, if any, or limited to the maximum benefits provided under the contract.

(3) A Medicare supplement contract shall provide that benefits and prepaid or periodic charges under the contract shall be suspended at the request of the subscriber or enrollee for the period (not to exceed 24 months) in which the subscriber or enrollee has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the subscriber or enrollee notifies the plan of that contract within 90 days after the date the individual becomes entitled to that assistance. Upon receipt of timely notice, the plan shall return to the subscriber or enrollee that portion of the prepaid or periodic charge attributable to the period of medicaid eligibility.

If the suspension occurs and if the subscriber or enrollee loses entitlement to that medical assistance, the contract shall be automatically reinstituted, effective as of the date of termination of entitlement, if the subscriber or enrollee provides notice of loss of the entitlement within 90 days after the date of the loss and pays the prepaid or periodic charge attributable to the period, effective as of the date of termination of entitlement. Reinstitution of coverage shall not provide for any waiting period with respect to treatment of preexisting conditions. The reinstitution coverage shall be substantially equivalent to coverage in effect before the date of the suspension. When coverage is reinstituted the classification of prepaid or periodic charges shall be on terms at least as favorable to the subscriber or enrollee as the prepaid or periodic charge classification terms that would have applied to the subscriber or enrollee had the coverage not been suspended.

(b) Any plan contract that primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, shall include the following ‘‘core’’ package of benefits. This ‘‘core’’ package of benefits shall be referred to as standardized Medicare supplement benefit plan ‘‘A’’. A plan may make available to prospective subscribers and enrollees any of the other standardized Medicare supplement benefit plans in addition to the basic ‘‘core’’ package, but not in lieu thereof.

(1) Coverage of Part A Medicare Eligible Expenses for incurred hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A Eligible Expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(c) Plans may also make available any of the other standardized Medicare supplement benefit plans set forth below in addition to the basic ''core'' package, but not in lieu thereof. No groups, packages, or combinations of Medicare supplement benefits other than the standardized Medicare supplement benefit plans listed in this subdivision shall be offered for sale in this state, except as may be permitted. Benefit plans shall conform in structure, language, designation, and format to the standard benefit plans ''A'' through ''J'' listed in this section. The benefits shall be listed in the order shown in this section. For purposes of this section, ''structure, language, and format'' mean style, arrangement, and overall content of a benefit.

(d) In addition to the standardized Medicare supplement benefit plan ''A'', the nine other standardized benefit plans that may be offered are defined as follows:

(1) Standardized Medicare supplement benefit plan ''B'' shall include only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible as defined in paragraph (1) of subdivision (e).

(2) Standardized Medicare supplement benefit plan ''C'' shall include only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs (1), (2), (3), and (8) of subdivision (e), respectively.

(3) Standardized Medicare supplement benefit plan ''D'' shall include only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in paragraphs (1), (2), (8), and (10) of subdivision (e), respectively.

(4) Standardized Medicare supplement benefit plan ''E'' shall include only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in paragraphs (1), (2), (8), and (9) of subdivision (e), respectively.

(5) Standardized Medicare supplement benefit plan ''F'' shall include only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country, as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (e), respectively.

(6) Standardized Medicare supplement benefit plan ''G'' shall include only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 Percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in paragraphs (1), (2), (4), (8), and (10) of subdivision (e), respectively.

(7) Standardized Medicare supplement benefit plan ''H'' shall consist of only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Outpatient Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country, as defined in paragraphs (1), (2), (6), and (8) of subdivision (e), respectively.

(8) Standardized Medicare supplement benefit plan ''I'' shall consist of only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 Percent of the Medicare Part B Excess Charges, Basic Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit, as defined in paragraphs (1), (2), (5), (6), (8), and (10) of subdivision (e), respectively.

(9) Standardized Medicare supplement benefit plan ''J'' shall consist of only the following: the Core Benefit as defined in subdivision (b) plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit, as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (e), respectively.

(e) The terms used in the standardized Medicare supplement benefit plans described in subdivision (d) are defined as follows:

(1) ''Medicare Part A Deductible'' means coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) ''Skilled nursing facility care'' means coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(3) ''Medicare Part B Deductible'' means coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) ''Eighty Percent of the Medicare Part B Excess Charges'' means coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) ''One Hundred Percent of the Medicare Part B Excess Charges'' means coverage for all of the differences between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) ''Basic Outpatient Prescription Drug Benefit'' means coverage for 50 percent of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the enrollee per calendar year, to the extent not covered by Medicare.

(7) ''Extended Outpatient Prescription Drug Benefit'' means coverage for 50 percent of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the enrollee per calendar year, to the extent not covered by Medicare.

(8) ''Medically Necessary Emergency Care in a Foreign Country'' means coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000).

(9) ''Preventive Medical Care Benefit'' means coverage for the following preventive health services:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph

(B) and patient education to address preventive health care measures.

(B) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(i) Fecal occult blood test or digital rectal examination or both.

(ii) Mammogram.

(iii) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.

(iv) Pure tone, air only, hearing screening test, administered or ordered by a physician.

(v) Serum cholesterol screening every five years.

(vi) Thyroid function test.

(vii) Diabetes screening.

(C) Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every 10 years.

(D) Any other tests or preventive measures determined appropriate by the attending physician. Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) ''At-Home Recovery Benefit'' means coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

(i) ''Activities of daily living'' include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) ''Care provider'' means a home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) ''Home'' means any place used by the enrollee as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the enrollee's place of residence.

(iv) ''At-home recovery visit'' means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(B) The following coverage limitations apply to this benefit:

(i) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit, not to exceed one thousand six hundred dollars ($1,600) per calendar year.

(ii) A plan may require that the at-home recovery services, including the number of visits, frequency and the type of services, be certified by an attending physician as necessary for a condition for which Medicare has approved a home health care plan. The total number of at-home recovery visits may be limited to the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment. The number of visits per week may be limited to seven visits.

(iii) A plan may require that all at-home recovery visits for a particular Medicare benefit period must be used within an eight-week period following the last Medicare-approved home health care visit.

(C) Coverage is excluded for any of the following:

(i) Home care visits paid for by Medicare or other government programs.

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(f) A plan may, with the prior approval of the director, offer Medicare supplement contracts with new or innovative benefits in addition to the benefits required under this section. The benefits may include benefits that are appropriate to Medicare supplement coverage, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement contracts consistent with this chapter.

SEC. 83. Section 1358.19 of the Health and Safety Code is amended to read:

1358.19. The director may authorize a plan to offer Medicare Select contracts pursuant to Section 4358 of the Omnibus Budget Reconciliation Act (‘‘OBRA’’) of 1990 if the director finds that the plan’s Medicare supplement contracts are in compliance with the Knox-Keene Act, including the following additional requirements for Medicare Select contracts:

(a) A Medicare Select plan shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select contract to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and charges of the Medicare Select contract with the following:

(A) Other Medicare supplement contracts, policies, or certificates offered by the plan and its affiliates.

(B) Medicare select policies, contracts, and certificates offered by other companies.

(2) A description, including address, phone number and hours of operation, of the providers contracting with the plan, including primary care physicians, specialty physicians, hospitals, and pharmacies.

(3) A description of the restricted provider provisions, including charges when providers other than those contracting with the plan are utilized.

(4) A description of coverage for emergency and urgently needed care and out-of-service area coverage.

(5) A description of covered services that require a referral by a plan provider or plan preauthorization.

(6) A description of the subscriber or enrollees' rights to purchase any other Medicare supplement contract otherwise offered by the plan.

(7) A description of the Medicare Select plan's quality of care review program and grievance procedure.

(b) Prior to the sale of a Medicare Select contract, a plan shall obtain from the applicant a signed and dated form stating that the applicant has received the information required to be provided pursuant to subdivision (a) and that the applicant understands the restrictions of the Medicare Select contract.

(c) At the time of initial purchase, a Medicare Select plan shall make available to each applicant for a Medicare Select contract the opportunity to purchase any Medicare supplement contract, policy, or certificate otherwise offered by the plan or its affiliates.

(1) At the request of an enrollee under a Medicare Select contract, a Medicare Select plan shall make available to the enrollee the opportunity to purchase a Medicare supplement contract offered by the plan which has comparable or lesser benefits and which does not contain a restricted provider network provision, if any such Medicare Select contract is offered by the plan. The plan shall make those contracts available without regard to the health status of the enrollee after the Medicare supplement contract has been in force for six months.

(2) For the purposes of this subdivision, a Medicare supplement contract will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select contract being replaced. For the purposes of this paragraph ''significant benefit'' means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(d) Medicare Select contracts shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select contracts, policies, and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each enrollee under a Medicare Select plan the opportunity to purchase a Medicare supplement contract offered by the plan which has comparable or lesser benefits and which does not contain a restricted provider network provision, if any such Medicare supplement contract is offered by the plan. The plan shall make those contracts available without regard to the health status of the enrollee after the Medicare supplement contract has been in force for six months.

(2) For the purposes of this subdivision, a Medicare supplement contract will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select contract being replaced. For the purposes of this paragraph ''significant benefit'' means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(e) A plan offering Medicare Select contracts shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program. A Medicare Select plan shall not issue a Medicare Select contract in this state until the contract has been approved by the director.

SEC. 84. Section 1358.21 of the Health and Safety Code is amended to read:

1358.21. (a) A plan may discontinue the availability of a Medicare supplement contract if the plan provides to the director in writing its decision at least 60 days prior to discontinuing the availability of the contract. After receipt of the notice by the director, the plan shall no longer offer for sale the contract in this state. A contract shall not be considered to be available for purchase unless the plan has actively offered it for sale in the previous 12 months.

(b) A plan that discontinues the availability of a contract pursuant to subdivision (a) shall not file for approval a new contract of the same type for the same standardized Medicare supplement benefit plan as the discontinued contract for a period of five years after the plan provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

(c) The sale or other transfer of Medicare supplement business to another company shall be considered a discontinuance for the purpose of this section.

SEC. 85. Section 1359 of the Health and Safety Code is amended to read:

1359. (a) The director may require that solicitors and solicitor firms, and principal persons engaged in the supervision of solicitation for plans of solicitor firms, meet such reasonable and appropriate standards with respect to training, experience, and other qualifications as the director finds necessary and appropriate in the

public interest or for the protection of subscribers, enrollees, and plans. For such purposes, the director may do the following:

(1) Appropriately classify such persons and individuals.

(2) Specify that all or any portion of such standards shall be applicable to any such class.

(3) Require individuals in any such class to pass examinations prescribed in accordance with such rules.

(b) The director may prescribe by rule reasonable fees and charges to defray the costs of carrying out this section, including, but not limited to, fees for any examination administered by the director or under his or her direction.

SEC. 86. Section 1360.1 of the Health and Safety Code is amended to read:

1360.1. It is unlawful for any person, including a plan, subject to this chapter to represent or imply in any manner that the person or plan has been sponsored, recommended, or approved, or that the person's or plan's abilities or qualifications have in any respect been passed upon, by the director. Nothing in this section prohibits a statement (other than in a paid advertisement) that a person or plan holds a license under this chapter, if such statement is true and if the effect of such licensing is not misrepresented.

SEC. 87. Section 1361 of the Health and Safety Code is amended to read:

1361. (a) Except as provided in subdivision (b), no plan shall publish or distribute, or allow to be published or distributed on its behalf, any advertisement not subject to Section 1352.1 unless (1) a true copy thereof has first been filed with the director, at least 30 days prior to any such use, or any shorter period as the director by rule or order may allow, and (2) the director by notice has not found the advertisement, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this chapter or the rules thereunder, and specified the deficiencies, within the 30 days or any shorter time as the director by rule or order may allow.

(b) Except as provided in subdivision (c), a licensed plan which has been continuously licensed under this chapter for the preceding 18 months may publish or distribute or allow to be published or distributed on its behalf an advertisement not subject to Section 1352.1 without having filed the same for the director's prior approval, if the plan and the material comply with each of the following conditions:

(1) The advertisement or a material provision thereof has not been previously disapproved by the director by written notice to the plan and the plan reasonably believes that the advertisement does not violate any requirement of this chapter or the rules thereunder.

(2) The plan files a true copy of each new or materially revised advertisement, used by it or by any person acting on behalf of the plan, with the director not later than 10 business days after

publication or distribution of the advertisement or within such additional period as the director may allow by rule or order.

(c) If the director finds that any advertisement of a plan has materially failed to comply with this chapter or the rules thereunder, the director may, by order, require the plan to publish in the same or similar medium, an approved correction or retraction of any untrue, misleading, or deceptive statement contained in the advertising, and may prohibit the plan from publishing or distributing, or allowing to be published or distributed on its behalf the advertisement or any new materially revised advertisement without first having filed a copy thereof with the director, 30 days prior to the publication or distribution thereof, or any shorter period specified in the order. An order issued under this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the advertisements submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this chapter and the rules thereunder.

(d) A licensed plan or other person regulated under this chapter may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the director.

(e) The director by rule or order may classify plans and advertisements and exempt certain classes, wholly or in part, either unconditionally or upon specified terms and conditions or for specified periods, from the application of subdivisions (a) and (b).

SEC. 88. Section 1363 of the Health and Safety Code, as amended by Section 2 of Chapter 994 of the Statutes of 1998, is amended to read:

1363. (a) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability which is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care or specialty care physician based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 12 (commencing with Section 1399.80).

(17) A notice as required by Section 1364.6.

(b) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.
(B) Lifetime maximums.
(C) Professional services.
(D) Outpatient services.
(E) Hospitalization services.
(F) Emergency health coverage.
(G) Ambulance services.
(H) Prescription drug coverage.
(I) Durable medical equipment.
(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION

OF COVERAGE BENEFITS AND LIMITATIONS.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. Where the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract which may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare program pursuant to Title XVIII and Title XIX of the Social Security Act.

SEC. 90. Section 1364 of the Health and Safety Code is amended to read:

1364. Where the director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by a plan for the purpose of influencing persons to

become members of a plan shall contain such supplemental disclosure information as the director may require.

SEC. 91. Section 1365 of the Health and Safety Code is amended to read:

1365. (a) An enrollment or a subscription may not be canceled or not renewed except for the following:

(1) Failure to pay the charge for such coverage if the subscriber has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

(2) Fraud or deception in the use of the services or facilities of the plan or knowingly permitting such fraud or deception by another.

(3) Such other good cause as is agreed upon in the contract between the plan and a group or the subscriber.

(b) An enrollee or subscriber who alleges that an enrollment or subscription has been canceled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review by the director. If the director determines that a proper complaint exists under the provisions of this section, the director shall notify the plan. Within 15 days after receipt of such notice, the plan shall either request a hearing or reinstate the enrollee or subscriber. If, after hearing, the director determines that the cancellation or failure to renew is contrary to subdivision (a), the director shall order the plan to reinstate the enrollee or subscriber. A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or nonrenewal to and including the date of reinstatement.

(c) This section shall not abrogate any preexisting contracts entered into prior to the effective date of this chapter between a subscriber or enrollee and a health care service plan or a specialized health care service plan including, but not limited to, the financial liability of such plan, except that each plan shall, if directed to do so by the director, exercise its authority, if any, under any such preexisting contracts to conform them to the provisions of subdivision (a).

SEC. 92. Section 1365.5 of the Health and Safety Code is amended to read:

1365.5. (a) No health care service plan or specialized health care service plan shall refuse to enter into any contract or shall cancel or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise.

(b) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any

limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise; except that premium, price, or charge differentials because of the sex or age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited. Nothing in this section shall be construed to permit a health care service plan to charge different premium rates to individual enrollees within the same group solely on the basis of the enrollee's sex.

(c) It shall be deemed a violation of subdivision (a) for any health care service plan to utilize marital status, living arrangements, occupation, gender, beneficiary designation, zip codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Nothing in this section shall be construed to alter in any manner the existing law prohibiting health care service plans from conducting tests for the presence of human immunodeficiency virus or evidence thereof.

(d) This section shall not be construed to limit the authority of the director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.

SEC. 93. Section 1366.4 of the Health and Safety Code is amended to read:

1366.4. (a) A medical group, physician, or independent practice association that contracts with a health care service plan may enter into contracts with licensed nonphysician providers to provide services, as defined in Section 1300.67(a)(1) of Title 10 of the California Code of Regulations, to plan enrollees covered by the contract between the plan and the group, physician, or association.

(b) The licensed nonphysician provider described in subdivision (a) that contracts with a medical group, physician, or independent practice association may directly bill, if direct billing is otherwise permitted by law, a health care service plan for covered services pursuant to a contract with the health care service plan that specifies direct billing. Direct billing pursuant to this subdivision is permitted only to the extent that the same services are not billed for by the medical group, physician, or independent practice association.

(c) A health care service plan may require the nonphysician provider to complete an appropriate credentialing process.

(d) Every health care service plan may either list licensed nonphysician providers that contract with medical groups, physicians, and independent practice associations pursuant to subdivision (b) in any listing or directory of plan health care providers that is provided to enrollees or to the public, or may include

a notification in the plan's evidence of coverage or provider list that the health care service plan has contracts with nonphysician providers, pursuant to subdivision (b), and may list the types of contracted nonphysician providers. The notification may inform an enrollee that he or she may obtain a list of the nonphysician providers by contacting his or her primary or specialist medical group. The listing may indicate whether licensed nonphysician providers may be accessed directly by enrollees.

(e) Nothing in this section shall be construed to authorize, or otherwise require the director to approve, a risk-sharing arrangement between a plan and a provider.

SEC. 94. Section 1367 of the Health and Safety Code is amended to read:

1367. Each health care service plan and, if applicable, each specialized health care service plan shall meet the following requirements:

(a) All facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 10 of the California Code of Regulations.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions

are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) All contracts with subscribers and enrollees, including group contracts, and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(i) Each health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service which health care service plans shall be required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) No health care service plan shall require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

SEC. 95. Section 1367.02 of the Health and Safety Code is amended to read:

1367.02. (a) On or before July 1, 1999, for purposes of public disclosure, every health care service plan shall file with the department a description of any policies and procedures related to economic profiling utilized by the plan and its medical groups and individual practice associations. The filing shall describe how these policies and procedures are used in utilization review, peer review,

incentive and penalty programs, and in provider retention and termination decisions. The filing shall also indicate in what manner, if any, the economic profiling system being used takes into consideration risk adjustments that reflect case mix, type and severity of patient illness, age of patients, and other enrollee characteristics that may account for higher or lower than expected costs or utilization of services. The filing shall also indicate how the economic profiling activities avoid being in conflict with subdivision (g) of Section 1367, which requires each plan to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. Any changes to the policies and procedures shall be filed with the director pursuant to Section 1352. Nothing in this section shall be construed to restrict or impair the department, in its discretion, from utilizing the information filed pursuant to this section for purposes of ensuring compliance with this chapter.

(b) The director shall make each plan's filing available to the public upon request. The director shall not publicly disclose any information submitted pursuant to this section that is determined by the director to be confidential pursuant to state law.

(c) Each plan that uses economic profiling shall, upon request, provide a copy of economic profiling information related to an individual provider, contracting medical group, or individual practice association to the profiled individual, group, or association. In addition, each plan shall require as a condition of contract that its medical groups and individual practice associations that maintain economic profiles of individual providers shall, upon request, provide a copy of individual economic profiling information to the individual providers who are profiled. The economic profiling information provided pursuant to this section shall be provided upon request until 60 days after the date upon which the contract between the plan and the individual provider, medical group, or individual practice association terminates, or until 60 days after the date the contract between the medical group or individual practice association and the individual provider terminates, whichever is applicable.

(d) For the purposes of this article, ''economic profiling'' shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

SEC. 96. Section 1367.3 of the Health and Safety Code is amended to read:

1367.3. (a) On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive care of children. This section shall apply to children 17 and 18 years

of age, except as provided in paragraph (4) of subdivision (b). Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to a plan which, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described herein.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.

(B) The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, unless the State Department of Health Services determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) For health care service plan contracts within the scope of this section that are issued, amended, or renewed on and after January 1, 1993, screening for blood lead levels in children at risk for lead poisoning, as determined by a physician and surgeon affiliated with the plan, when the screening is prescribed by a physician and surgeon affiliated with the plan. This subparagraph shall be applicable to all children and shall not be limited to children 17 and 18 years of age.

SEC. 97. Section 1367.35 of the Health and Safety Code is amended to read:

1367.35. (a) On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under terms and conditions agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to each plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules

thereunder relate to the provision of the preventive health care services described in this section.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.

(B) The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, unless the State Department of Health Services determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.

(2) Provide for all of the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

SEC. 98. Section 1367.695 of the Health and Safety Code is amended to read:

1367.695. (a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Commencing January 1, 1999, every health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a health care service plan may establish reasonable provisions governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct

access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section shall not be construed to diminish the provisions of Section 1367.69.

(e) The Department of Managed Care shall report to the Legislature, on or before January 1, 2000, on the implementation of this section.

SEC. 99. Section 1367.10 of the Health and Safety Code is amended to read:

1367.10. (a) Every health care service plan shall include within its disclosure form and within its evidence of coverage a statement clearly describing how participation in the plan may affect the choice of physician, hospital, or other health care providers, the basic method of reimbursement, including the scope and general methods of payment made to its contracting providers of health care services, and whether financial bonuses or any other incentives are used. The disclosure form and evidence of coverage shall indicate that if an enrollee wishes to know more about these issues, the enrollee may request additional information from the health care service plan, the enrollee's provider, or the provider's medical group or independent practice association regarding the information required pursuant to subdivision (b).

(b) If a plan, medical group, independent practice association, or participating health care provider uses or receives financial bonuses or any other incentives, the plan, medical group, independent practice association, or health care provider shall provide a written summary to any person who requests it that includes all of the following:

(1) A general description of the bonus and any other incentive arrangements used in its compensation agreements. Nothing in this section shall be construed to require disclosure of trade secrets or commercial or financial information that is privileged or confidential, such as payment rates, as determined by the director, pursuant to state law.

(2) A description regarding whether, and in what manner, the bonuses and any other incentives are related to a provider's use of referral services.

(c) The statements and written information provided pursuant to subdivisions (a) and (b) shall be communicated in clear and simple language that enables consumers to evaluate and compare health care service plans.

(d) The plan shall clearly inform prospective enrollees that participation in that plan will affect the person's choice of provider

by placing the following statement in a conspicuous place on all material required to be given to prospective enrollees including promotional and descriptive material, disclosure forms, and certificates and evidences of coverage:

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

It is not the intent of this section to require that the names of individual health care providers be enumerated to prospective enrollees.

If the health care service plan provides a list of providers to patients or contracting providers, the plan shall include within the provider listing a notification that enrollees may contact the plan in order to obtain a list of the facilities with which the health care service plan is contracting for subacute care and/or transitional inpatient care.

SEC. 100. Section 1367.15 of the Health and Safety Code is amended to read:

1367.15. (a) This section shall apply to individual health care service plan contracts and plan contracts sold to employer groups with fewer than two eligible employees as defined in subdivision (b) of Section 1357 covering hospital, medical, or surgical expenses, which is issued, amended, delivered, or renewed on or after January 1, 1994.

(b) As used in this section, ''block of business'' means individual plan contracts or plan contracts sold to employer groups with fewer than two eligible employees as defined in subdivision (b) of Section 1357, with distinct benefits, services, and terms. A ''closed block of business'' means a block of business for which a health care service plan ceases to actively offer or sell new plan contracts.

(c) No block of business shall be closed by a health care service plan unless (1) the plan permits an enrollee to receive health care services from any block of business that is not closed and which provides comparable benefits, services, and terms, with no additional underwriting requirement, or (2) the plan pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any plan contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool.

(d) A block of business shall be presumed closed if either of the following is applicable:

(1) There has been an overall reduction in that block of 12 percent in the number of in force plan contracts for a period of 12 months.

(2) That block has less than 1,000 enrollees in this state. This presumption shall not apply to a block of business initiated within the

previous 24 months, but notification of that block shall be provided to the director pursuant to subdivision (e).

The fact that a block of business does not meet one of the presumptions set forth in this subdivision shall not preclude a determination that it is closed as defined in subdivision (b).

(e) A health care service plan shall notify the director in writing within 30 days of its decision to close a block of business or, in the absence of an actual decision to close a block of business, within 30 days of its determination that a block of business is within the presumption set forth in subdivision (d). When the plan decides to close a block, the written notice shall fully disclose all information necessary to demonstrate compliance with the requirements of subdivision (c). When the plan determines that a block is within the presumption, the written notice shall fully disclose all information necessary to demonstrate that the presumption is applicable. In the case of either notice, the plan shall provide additional information within 15 days after any request of the director.

(f) A health care service plan shall preserve for a period of not less than five years in an identified location and readily accessible for review by the director all books and records relating to any action taken by a plan pursuant to subdivision (c).

(g) No health care service plan shall offer or sell any contract, or provide misleading information about the active or closed status of a block of business, for the purpose of evading this section.

(h) A health care service plan shall bring any blocks of business closed prior to the effective date of this section into compliance with the terms of this section no later than December 31, 1994.

(i) This section shall not apply to health care service plan contracts providing small employer health coverage to individuals or employer groups with fewer than two eligible employees if that coverage is provided pursuant to Article 3.1 (commencing with Section 1357) and, with specific reference to coverage for individuals or employer groups with fewer than two eligible employees, is approved by the director pursuant to Section 1357.15, provided a plan electing to sell coverage pursuant to this subdivision shall do so until such time as the plan ceases to market coverage to small employers and complies with subdivision (c) of Section 1357.11.

(j) This section shall not apply to coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, dental, vision, or conversion coverage.

SEC. 101. Section 1367.24 of the Health and Safety Code is amended to read:

1367.24. (a) Every health care service plan that provides prescription drug benefits shall maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary nonformulary prescription drug. On or before July 1, 1999, every health care service plan that provides prescription

drug benefits shall file with the department a description of its process, including timelines, for responding to authorization requests for nonformulary drugs. Any changes to this process shall be filed with the department pursuant to Section 1352. Each plan shall provide a written description of its most current process, including timelines, to its prescribing providers. For purposes of this section, a prescribing provider shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an enrollee.

(b) Any plan that disapproves a request made pursuant to subdivision (a) by a prescribing provider to obtain authorization for a nonformulary drug shall provide the reasons for the disapproval in a notice provided to the enrollee. The notice shall indicate that the enrollee may file a grievance with the plan if the enrollee objects to the disapproval, including any alternative drug or treatment offered by the plan. The notice shall comply with subdivision (b) of Section 1368.02.

(c) The process described in subdivision (a) by which prescribing providers may obtain authorization for medically necessary nonformulary drugs shall not apply to a nonformulary drug that has been prescribed for an enrollee in conformance with the provisions of Section 1367.22.

(d) The process described in subdivision (a) by which enrollees may obtain medically necessary nonformulary drugs, including specified timelines for responding to prescribing provider authorization requests, shall be described in evidence of coverage and disclosure forms, as required by subdivision (a) of Section 1363, issued on or after July 1, 1999.

(e) Every health care service plan that provides prescription drug benefits shall maintain, as part of its books and records under Section 1381, all of the following information, which shall be made available to the director upon request:

(1) The complete drug formulary or formularies of the plan, if the plan maintains a formulary, including a list of the prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over other drugs.

(2) Records developed by the pharmacy and therapeutic committee of the plan, or by others responsible for developing, modifying, and overseeing formularies, including medical groups, individual practice associations, and contracting pharmaceutical benefit management companies, used to guide the drugs prescribed for the enrollees of the plan, that fully describe the reasoning behind formulary decisions.

(3) Any plan arrangements with prescribing providers, medical groups, individual practice associations, pharmacists, contracting pharmaceutical benefit management companies, or other entities

that are associated with activities of the plan to encourage formulary compliance or otherwise manage prescription drug benefits.

(f) If a plan provides prescription drug benefits, the department shall, as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, review the performance of the plan in providing those benefits, including, but not limited to, a review of the procedures and information maintained pursuant to this section, and describe the performance of the plan as part of its report issued pursuant to Section 1380.

(g) The director shall not publicly disclose any information reviewed pursuant to this section that is determined by the director to be confidential pursuant to state law.

(h) Nothing in this section shall be construed to restrict or impair the application of any other provision of this chapter, including, but not limited to, Section 1367, which includes among its requirements that a health care service plan furnish services in a manner providing continuity of care and demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management. Subdivision (c) of Section 1367.24, which establishes an exemption if a drug has been prescribed in conformance with Section 1367.22, shall have no effect unless Section 1367.22 of the Health and Safety Code, as added by Assembly Bill 974 of the 1997–98 Regular Session, takes effect on or before July 1, 1999.

SEC. 103. Section 1368.02 of the Health and Safety Code, as amended by Section 3 of Chapter 377 of the Statutes of 1998, is amended to read:

1368.02. (a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving complaints regarding health care service plans regulated by the director.

(b) Every health care service plan shall publish the department's toll-free telephone number, the California Relay Service's toll-free telephone numbers for the hearing and speech impaired, the plan's telephone number, and the department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number, and the department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

''The California Department of Managed Care is responsible for regulating health care service plans. The department has a toll-free

telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at [plan's telephone number] and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.''

(c) (1) There is within the department an Office of Patient Advocate, which shall be known and may be cited as the Gallegos-Rosenthal Patient Advocate Program, to represent the interests of enrollees served by health care service plans regulated by the department. The goal of the office shall be to help enrollees secure health care services to which they are entitled under the laws administered by the department.

(2) The office shall be headed by a patient advocate recommended to the Governor by the Secretary of the Business, Transportation and Housing Agency. The patient advocate shall be appointed by and serve at the pleasure of the Governor.

(3) The duties of the office shall be determined by the secretary, in consultation with the director, and shall include, but not be limited to:

(A) Developing educational and informational guides for consumers describing enrollee rights and responsibilities, and informing enrollees on effective ways to exercise their rights to secure health care services. The guides shall be easy to read and understand, available in English and other languages, and shall be made available to the public by the department, including access on the department's Internet website and through public outreach and educational programs.

(B) Compiling an annual publication, to be made available on the department's Internet website, of a quality of care report card including but not limited to health care service plans.

(C) Rendering advice and assistance to enrollees regarding procedures, rights, and responsibilities related to the use of health care service plan grievance systems, the department's system for

reviewing unresolved grievances, and the independent review process.

(D) Making referrals within the department regarding studies, investigations, audits, or enforcement that may be appropriate to protect the interests of enrollees.

(E) Coordinating and working with other government and nongovernment patient assistance programs and health care ombudsprograms.

(4) The director, in consultation with the patient advocate, shall provide for the assignment of personnel to the office. The department may employ or contract with experts when necessary to carry out functions of the office. The annual budget for the office shall be separately identified in the annual budget request of the department.

(5) The office shall have access to department records including, but not limited to, information related to health care service plan audits, surveys, and enrollee grievances. The department shall assist the office in compelling the production and disclosure of any information the office deems necessary to perform its duties, from entities regulated by the department, if the information is determined by the department's legal counsel to be subject, under existing law, to production or disclosure to the department.

(6) The patient advocate shall annually issue a public report on the activities of the office, and shall appear before the appropriate policy and fiscal committees of the Senate and Assembly, if requested, to report and make recommendations on the activities of the office.

SEC. 105. Section 1370 of the Health and Safety Code is amended to read:

1370. Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan

or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.

This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

SEC. 107. Section 1371.4 of the Health and Safety Code is amended to read:

1371.4. (a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

SEC. 108. Section 1372 of the Health and Safety Code is amended to read:

1372. Subject to the applicable provisions of this chapter, a plan may offer one or more plan contracts or specialized health care service plan contracts, except that a specialized health care service plan contract shall not offer one or more basic health care services except as may be permitted by rule or order of the director. Advertising, disclosure forms, contract forms, and evidences of coverage for more than one type of plan contract or specialized

health care service plan contract, or both, may not be used except as authorized by the director pursuant to this chapter.

SEC. 109. Section 1373 of the Health and Safety Code is amended to read:

1373. (a) A plan contract may not provide an exception for other coverage where the other coverage is entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

Each plan contract shall be interpreted not to provide an exception for the Medi-Cal or medicaid benefits.

A plan contract shall not provide an exemption for enrollment because of an applicant's entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

A plan contract may not provide that the benefits payable thereunder are subject to reduction if the individual insured has entitlement to the Medi-Cal or medicaid benefits.

(b) A plan contract that provides coverage, whether by specific benefit or by the effect of general wording, for sterilization operations or procedures shall not impose any disclaimer, restriction on, or limitation of, coverage relative to the covered individual's reason for sterilization.

As used in this section, ''sterilization operations or procedures'' shall have the same meaning as that specified in Section 10120 of the Insurance Code.

(c) Every plan contract that provides coverage to the spouse or dependents of the subscriber or spouse shall grant immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any subscriber or spouse covered and to each minor child placed for adoption from and after the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the subscriber's or spouse's right to control the health care of the child placed for adoption. No such plan may be entered into or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn infants of, or children placed for

adoption with, a subscriber or spouse covered as required by this subdivision.

(d) Every plan contract that provides that coverage of a dependent child of a subscriber shall terminate upon attainment of the limiting age for dependent children specified in the plan, shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (2) chiefly dependent upon the subscriber for support and maintenance, provided proof of the incapacity and dependency is furnished to the plan by the member within 31 days of the request for the information by the plan or group plan contractholder and subsequently as may be required by the plan or group plan contractholder, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(e) A plan contract which provides coverage, whether by specific benefit or by the effect of general wording, for both an employee and one or more covered persons dependent upon the employee and provides for an extension of the coverage for any period following a termination of employment of the employee shall also provide that this extension of coverage shall apply to dependents upon the same terms and conditions precedent as applied to the covered employee, for the same period of time, subject to payment of premiums, if any, as required by the terms of the policy and subject to any applicable collective bargaining agreement.

(f) A group contract shall not discriminate against handicapped persons or against groups containing handicapped persons. Nothing in this subdivision shall preclude reasonable provisions in a plan contract against liability for services or reimbursement of the handicap condition or conditions relating thereto, as may be allowed by rules of the director.

(g) Every group contract shall set forth the terms and conditions under which subscribers and enrollees may remain in the plan in the event the group ceases to exist, the group contract is terminated or an individual subscriber leaves the group, or the enrollees' eligibility status changes.

(h) (1) A health care service plan or specialized health care service plan may provide for coverage of, or for payment for, professional mental health services, or vision care services, or for the exclusion of these services. If the terms and conditions include coverage for services provided in a general acute care hospital or an acute psychiatric hospital as defined in Section 1250 and do not restrict or modify the choice of providers, the coverage shall extend to care provided by a psychiatric health facility as defined in Section 1250.2 operating pursuant to licensure by the State Department of Mental Health. A health care service plan that offers outpatient

mental health services but does not cover these services in all of its group contracts shall communicate to prospective group contractholders as to the availability of outpatient coverage for the treatment of mental or nervous disorders.

(2) No plan shall prohibit the member from selecting any psychologist who is licensed pursuant to the Psychology Licensing Law (Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code), any optometrist who is the holder of a certificate issued pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code or, upon referral by a physician and surgeon licensed pursuant to the Medical Practice Act (Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code), (i) any marriage, family, and child counselor who is the holder of a license under Section 4980.50 of the Business and Professions Code, (ii) any licensed clinical social worker who is the holder of a license under Section 4996 of the Business and Professions Code, or (iii) any registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master's degree in psychiatric-mental health nursing and two years of supervised experience in psychiatric-mental health nursing, at the time that the State Board of Registered Nurses produces and maintains a list of those psychiatric-mental health nurses who possess a master's degree in psychiatric-mental health nursing and two years of supervised experience in psychiatric-mental health nursing, to perform the particular services covered under the terms of the plan, and the certificate holder is expressly authorized by law to perform these services.

(3) Nothing in this section shall be construed to allow any certificate holder or licensee enumerated in this section to perform professional mental health services beyond his or her field or fields of competence as established by his or her education, training and experience.

(4) For the purposes of this section, ''marriage, family, and child counselor'' means a licensed marriage, family, and child counselor who has received specific instruction in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions which is equivalent to the instruction required for licensure on January 1, 1981.

(5) Nothing in this section shall be construed to allow a member to select and obtain mental health or psychological or vision care services from a certificate or licenseholder who is not directly affiliated with or under contract to the health care service plan or specialized health care service plan to which the member belongs. All health care service plans and individual practice associations that offer mental health benefits shall make reasonable efforts to make

available to their members the services of licensed psychologists. However, a failure of a plan or association to comply with the requirements of the preceding sentence shall not constitute a misdemeanor.

(6) As used in this subdivision, ''individual practice association'' means an entity as defined in subsection (5) of Section 1307 of the federal Public Health Service Act (42 U.S.C. Sec. 300e-1, subsec. (5)).

(7) Health care service plan coverage for professional mental health services may include community residential treatment services that are alternatives to inpatient care and which are directly affiliated with the plan or to which enrollees are referred by providers affiliated with the plan.

(i) If the plan utilizes arbitration to settle disputes, the plan contracts shall set forth the type of disputes subject to arbitration, the process to be utilized, and how it is to be initiated.

(j) A plan contract which provides benefits that accrue after a certain time of confinement in a health care facility shall specify what constitutes a day of confinement or the number of consecutive hours of confinement that are requisite to the commencement of benefits.

SEC. 110. Section 1373.95 of the Health and Safety Code is amended to read:

1373.95. (a) On or before July 1, 1996, every health care service plan that provides coverage on a group basis shall file with the Department of Managed Care, a written policy describing how the health plan shall facilitate the continuity of care for new enrollees receiving services during a current episode of care for an acute condition from a nonparticipating provider. This written policy shall describe the process used to facilitate the continuity of care, including the assumption of care by a participating provider. Notice of the policy and information regarding how enrollees may request a review under the policy shall be provided to all new enrollees, except those enrollees who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible enrollees upon request.

(b) The written policy shall describe how requests to continue services with an existing provider are reviewed by the plan. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the enrollee's treatment for the acute condition.

(c) A health care service plan may require any nonparticipating provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the health care service plan determines that a patient's health care treatment should temporarily continue with the patient's existing provider, the health care service

plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider.

(d) Nothing in this section shall require a health care service plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

(e) The written policy shall not apply to any enrollee who is offered an out-of-network option, or who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(f) This section shall not apply to health plan contracts that include out-of-network coverage under which the enrollee is able to obtain services from the enrollee's existing provider.

(g) For purposes of this section, ''provider'' refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.

SEC. 111. Section 1374.9 of the Health and Safety Code is amended to read:

1374.9. For violations of Section 1374.7, the commissioner may, after appropriate notice and opportunity for hearing, by order levy administrative penalties as follows:

(a) Any health care service plan that violates Section 1374.7, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

(b) The administrative penalties shall be paid to the Managed Care Fund.

(c) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the commissioner to enforce the provisions of this chapter.

SEC. 112. Section 1374.26 of the Health and Safety Code is amended to read:

1374.26. The director may, as required by this article, or from time to time as conditions warrant, pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, adopt reasonable regulations, and amendments and additions thereto, as are necessary to administer this article.

SEC. 113. Section 1374.27 of the Health and Safety Code is amended to read:

1374.27. The director may levy administrative penalties and may suspend or revoke the license or licenses issued to any health care service plan, after notice and hearing, to have violated this article or a regulation adopted pursuant to the authority of this article. Notice of hearing shall be accomplished and a hearing conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director shall have all of the powers granted therein.

The remedies available to the director pursuant to this article are not exclusive, and may be sought and employed in any combination with other remedies deemed advisable by the director to enforce the provisions of this article.

SEC. 114. Section 1374.28 of the Health and Safety Code is amended to read:

1374.28. In addition to any other penalty provided by law or the availability of any administrative procedure, if a health care service plan, after notice and hearing, is found to have violated this article, or regulations adopted pursuant to this article, or knowingly permits any person to do so, the director may suspend the authority of the plan to transact business.

SEC. 115. Section 1374.60 of the Health and Safety Code is amended to read:

1374.60. For purpose of this article, the following definitions shall apply:

(a) A ''point-of-service plan contract'' means any plan contract offered by a health care service plan whereby the health care service plan assumes financial risk for both ''in-network coverage or services'' and ''out-of-network coverage or services.''

The term ''point-of-service plan contract'' shall not apply to a plan contract where the out-of-network coverage or service is underwritten by an insurance company admitted in this state or is provided by a self-insured employer and is offered in conjunction with in-network coverage or services provided pursuant to a health care service plan contract.

(b) ''Out-of-network coverage or services'' means health care services received either from (1) providers who are not employed by, under contract with, or otherwise affiliated with the health care service plan, except for health care services received from these providers in an emergency or when referred or authorized by the plan under procedures specifically reviewed and approved by the director or (2) providers who are employed by, under contract with, or otherwise affiliated with a health care service plan in instances when the ''in-network coverage or services'' requirements for care set forth in the health care service plan's approved evidence of coverage are not met.

(c) ''In-network coverage or services'' means all of the following:

(1) All the health care services provided or offered under the requirements of this chapter that are received from a provider employed by, under contract with, or otherwise affiliated with the health care service plan and in accordance with the procedures set forth in the plan's approved evidence of coverage.

(2) Health care services received from a provider not affiliated with the health care service plan when the plan arranges for the enrollee to receive services from that provider.

(3) Out-of-area emergency care provided in accordance with the procedures set by the health care service plan to be followed in securing these services.

SEC. 116. Section 1374.64 of the Health and Safety Code is amended to read:

1374.64. (a) Only a plan that has been licensed under this chapter and in operation in this state for a period of five years or more, or a plan licensed under this chapter and operating in this state for a period of five or more years under a combination of (1) licensure under this chapter and (2) pursuant to a certificate of authority issued by the Department of Insurance may offer a point-of-service contract. A specialized health care service plan shall not offer a point-of-service plan contract unless this plan was formerly registered under the Knox-Mills Health Plan Act (Article 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code), as repealed by Chapter 941 of the Statutes of 1975, and offered point-of-service plan contracts previously approved by the director on July 1, 1976, and on September 1, 1993.

(b) A plan may offer a point-of-service plan contract only if the director has not found the plan to be in violation of any requirements, including administrative capacity, under this chapter or the rules adopted thereunder and the plan meets, at a minimum, the following financial criteria:

(1) The minimum financial criteria for a plan that maintains a minimum net worth of at least five million dollars ($5,000,000) shall be:

(A) (i) Initial tangible net equity so that the plan is not required to file monthly reports with the director as required by Section 1300.84.3(d)(1)(G) of Title 10 of the California Code of Regulations and then have and maintain adjusted tangible net equity to be determined pursuant to either of the following:

(I) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(1) or (2) of Title 10 of the California Code of Regulations, multiply 130 percent times the sum resulting from the addition of the plan's tangible net equity required by Section 1300.76(a)(1) or (2) of Title 10 of the California Code of Regulations and the number that equals 10

percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees.

(II) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(3) of Title 10 of the California Code of Regulations, recalculate the plan's tangible net equity under Section 1300.76(a)(3) of Title 10 of the California Code of Regulations excluding the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, add together the number resulting from this recalculation and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point of services enrollees, and multiply this sum times 130 percent, provided that the product of this multiplication must exceed 130 percent of the tangible net equity required by Section 1300.76(a)(3) of Title 10 of the California Code of Regulations so that the plan is not required to file monthly reports to the director as required by Section 1300.84.3(d)(1)(G) of Title 10 of the California Code of Regulations.

(ii) The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 10 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter.

(iii) The calculation of tangible net equity under any report to be filed by a plan offering a point-of-service plan contract under this article and required of a plan pursuant to Section 1384, and the regulations adopted thereunder, shall be on the basis of adjusted tangible net equity as determined under this subdivision.

(B) Demonstrates adequate working capital, including (i) a current ratio (current assets divided by current liabilities) of at least 1:1, after excluding obligations of officers, directors, owners, or affiliates, or (ii) evidence that the plan is now meeting its obligations on a timely basis and has been doing so for at least the preceding two years. Short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates shall not be excluded. For purposes of this subdivision, an obligation is considered short term if the repayment schedule is 30 days or fewer.

(C) Demonstrates a trend of positive earnings over the previous eight fiscal quarters.

(2) The minimum financial criteria for a plan that maintains a minimum net worth of at least one million five hundred thousand dollars ($1,500,000) but less than five million dollars ($5,000,000) shall be:

(A) (i) Initial tangible net equity so that the plan is not required to file monthly reports with the director as required by Section

1300.84.3(d)(1)(G) of Title 10 of the California Code of Regulations and then have and maintain adjusted tangible net equity to be determined pursuant to either of the following:

(I) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(1) or (2) of Title 10 of the California Code of Regulations, multiply 130 percent times the sum resulting from the addition of the plan's tangible net equity required by Section 1300.76(a)(1) or (2) of Title 10 of the California Code of Regulations and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees.

(II) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(3) of Title 10 of the California Code of Regulations, recalculate the plan's tangible net equity under Section 1300.76(a)(3) excluding the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, add together the number resulting from this recalculation and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-services enrollees, and multiply this sum times 130 percent, provided that the product of this multiplication must exceed 130 percent of the tangible net equity required by Section 1300.76(a)(3) of Title 10 of the California Code of Regulations so that the plan is not required to file monthly reports to the director as required by Section 1300.84.3(d)(1)(G) of Title 10 of the California Code of Regulations.

(ii) The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 10 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter.

(iii) The calculation of tangible net equity under any report to be filed by a plan offering a point-of-service plan contract under this article and required of a plan pursuant to Section 1384, and the regulations adopted thereunder, shall be on the basis of adjusted tangible net equity as determined under this subdivision.

(B) Demonstrates adequate working capital, including (i) a current ratio (current assets divided by current liabilities) of at least 1:1, after excluding obligations of officers, directors, owners, or affiliates or (ii) evidence that the plan is now meeting its obligations on a timely basis and has been doing so for at least the preceding two years. Short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates shall not be excluded. For purposes of this subdivision, an obligation is considered short term if the repayment schedule is 30 days or fewer.

(C) Demonstrates a trend of positive earnings over the previous eight fiscal quarters.

(D) Demonstrates to the director that it has obtained insurance for the cost of providing any point-of-service enrollee with out-of-network covered health care services, the aggregate value of which exceeds five thousand dollars ($5,000) in any year. This insurance shall obligate the insurer to continue to provide care for the period in which a premium was paid in the event a plan becomes insolvent. Where a plan cannot obtain insurance as required by this subparagraph, then a plan may demonstrate to the director that it has made other arrangements, acceptable to the director, for the cost of providing enrollees out-of-network health care services; but in this case the expenditure for total out-of-network costs for all enrollees in all point-of-service contracts shall be limited to a percentage, acceptable to the director, not to exceed 15 percent of total health care expenditures for all its enrollees.

(c) Within 30 days of the close of each month a plan offering point-of-service plan contracts under paragraph (2) of subdivision (b) shall file with the director a monthly financial report consisting of a balance sheet and statement of operations of the plan, which need not be certified, and a calculation of the adjusted tangible net equity required under subparagraph (A). The financial statements shall be prepared on a basis consistent with the financial statements furnished by the plan pursuant to Section 1300.84.2 of Title 10 of the California Code of Regulations. A plan shall also make special reports to the director as the director may from time to time require. Each report to be filed by a plan pursuant to this subdivision shall be verified by a principal officer of the plan as set forth in Section 1300.84.2(e) of Title 10 of the California Code of Regulations.

(d) If it appears to the director that a plan does not have sufficient financial viability, or organizational and administrative capacity to assure the delivery of health care services to its enrollees, the director may, by written order, direct the plan to discontinue the offering of a point-of-service plan contract. The order shall be effective immediately.

SEC. 117. Section 1374.66 of the Health and Safety Code is amended to read:

1374.66. Any health care service plan that offers a point-of-service plan contract may do all of the following:

(a) Limit or exclude coverage for specific types of services or conditions when obtained out-of-plan.

(b) Include annual out-of-pocket limits, copayments, and annual and lifetime maximum benefit limits for out-of-network coverage or services that are different or separate from any amounts or limits applied to in-network coverage or services, and may impose a deductible on coverage for out-of-network coverage or services.

(c) To the extent permitted under this chapter, may limit the groups to which a point-of-service plan contract is offered, and may adopt nondiscriminatory renewal guidelines under which one or more point-of-service plan contracts would be replaced with other than point-of-service plan contracts. If a point-of-service plan contract is sold to a group, then the group shall offer it to all members of that group who are eligible for coverage by the health care service plan.

(d) Treat as out-of-network services those services that an enrollee obtains from a provider affiliated with the plan, but not in accordance with the authorization procedures set forth in the health care service plan's approved evidence of coverage.

(e) Contracts between health care service plans and medical providers, for the purpose of providing medical services under point-of-service contracts, may include risk-sharing arrangements for out-of-network services, but only if the risk sharing arrangements meet all of the following conditions:

(1) The contracting medical provider agrees to participate in risk-sharing arrangements applicable to out-of-network services.

(2) If the medical provider is reimbursed on a capitated or prepaid basis, the contract shall clearly disclose the capitation or prepayment amount to be paid to the medical provider for in-network services received by enrollees under point-of-service contracts.

(3) Any capitation or prepayment amounts paid to the medical provider shall not place the medical provider directly at risk for or directly transfer liability for out-of-network services received by enrollees under point-of-service contracts.

(4) The risk-sharing arrangements for out-of-network services may provide a bonus or incentive to the medical provider to attempt to reduce the utilization of out-of-network services, but shall not place the medical provider at risk for any amounts in excess of the amounts used by the plan to budget for or fund the risk-sharing pool for out-of-network services.

(5) The contract between the medical provider and the plan shall clearly disclose the mathematical method by which funding for the risk-sharing arrangement is established, the mathematical method by which and the extent to which payments for out-of-network services are debited against the risk-sharing funds, and the method by which the risk-sharing arrangement is reconciled on no less than an annual basis.

(6) The contract is approved by the director.

SEC. 118. Section 1374.67 of the Health and Safety Code is amended to read:

1374.67. A health care service plan offering a point-of-service plan contract is subject to the following limitations:

(a) A health care service plan shall limit its offering of point-of-service plan contracts so that no more than 50 percent of the

plan's total premium revenue in any fiscal quarter is earned from point-of-service plan contracts.

(b) A health care service plan offering a point-of-service plan contract shall not expend in any fiscal-year quarter more than 20 percent of its total health care expenditures for all its enrollees for out-of-network services for point-of-service enrollees.

(c) If the amount specified in subdivision (a) or (b) is exceeded by 2 percent in any quarter, the health care service plan shall come into compliance with subdivisions (a) and (b) by the end of the next following quarter. If compliance with the amount specified in subdivisions (a) and (b) is not demonstrated in the health care service plan's next quarterly report, the director may prohibit the health care service plan from offering a point-of-service plan contract to new groups, or may require the health care service plan to amend one or more of its point-of-service contracts at the time of renewal to delete some or all of the out-of-network coverage or services as may be necessary for the plan to demonstrate compliance to the director's satisfaction.

(d) The limitation imposed by this section shall not apply to a plan which in substantial part indemnified subscribers and enrollees pursuant to contracts issued under such plan's former registration under the Knox-Mills Health Plan Act in 1975 and as of that date, and on September 1, 1993, was offering point-of-service plan contracts previously approved by the director.

SEC. 119. Section 1374.68 of the Health and Safety Code is amended to read:

1374.68. A health care service plan that offers a point-of-service plan contract shall do all of the following:

(a) Deposit with the director or, at the discretion of the director, with any organization or trustee acceptable to the director through which a custodial or controlled account is maintained, cash, securities, or any combination of these, which is acceptable to the director, that at all times have a fair market value equal to the greater of either one of the following:

(1) Two hundred thousand dollars ($200,000).

(2) One hundred twenty percent of the plan's current monthly claims payable plus incurred but not reported balance for coverage out-of-network coverage or services provided under point-of-service contracts.

(b) Track out-of-network point-of-service utilization separately from in-network utilization.

(c) Record point-of-service utilization in a manner that will permit utilization and cost reporting as the director may require.

(d) Demonstrate to the satisfaction of the director that the health care service plan has the fiscal, administrative, and marketing capacity to control its point-of-service plan contract enrollment, utilization, and costs so as not to jeopardize the financial viability or

organizational and administrative capacity of the health care service plan.

(e) Maintain the deposit required under subdivision (a) in a manner agreed to by the director, subject to subdivision (a) of Section 1377 and any regulations adopted thereunder.

(f) Any deposit made pursuant to this section shall be a credit against any deposit required by subdivision (a) of Section 1377.

SEC. 120. Section 1374.69 of the Health and Safety Code is amended to read:

1374.69. At least 20 business days prior to offering a point-of-service plan contract, a health care service plan shall file a notice of material modification in accordance with Section 1352. The notice of material modification shall include, but not be limited to, provisions specifying how the health care service plan shall accomplish all of the following:

(a) Design the benefit levels and conditions of coverage for in-network coverage and services and out-of-network point-of-service utilization.

(b) Provide or arrange for the provision of adequate systems to do all of the following:

(1) Process and pay claims for all out-of-network coverage and services.

(2) Generate accurate financial and utilization data and reports on a timely basis, so that it and any authorized regulatory agency can evaluate the health care service plan's experience with point-of-service plan contracts and monitor compliance with point-of-service plan contract projections established by the health care service plan and regulatory requirements.

(3) Track and monitor the quality of health care obtained out-of-network by plan enrollees to the extent reasonable and possible.

(4) Respond promptly to enrollee grievances and complaints, written or oral, including those regarding services obtained out-of-network.

(5) Meet the requirements for a point-of-service plan contract set forth in this section and any additional requirements that may be required by the director.

(c) Comply initially and on an ongoing basis with the requirements of this article.

(d) This section shall become operative July 1, 1995.

SEC. 121. Section 1374.71 of the Health and Safety Code is amended to read:

1374.71. No plan formerly registered under the Knox-Mills Health Plan Act (Article 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code) in 1975 shall be required to file a notice of material modification under Section 1374.69 or 1374.70 for any point-of-service plan

contract previously approved by the director under this chapter and offered by plan on or before September 1, 1993.

SEC. 122. Section 1375.1 of the Health and Safety Code is amended to read:

1375.1. (a) Every plan shall have and shall demonstrate to the director that it has all of the following:

(1) A fiscally sound operation and adequate provision against the risk of insolvency.

(2) Assumed full financial risk on a prospective basis for the provision of covered health care services, except that a plan may obtain insurance or make other arrangements for the cost of providing to any subscriber or enrollee covered health care services, the aggregate value of which exceeds five thousand dollars ($5,000) in any year, for the cost of covered health care services provided to its members other than through the plan because medical necessity required their provision before they could be secured through the plan, and for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for that fiscal year.

(3) A procedure for prompt payment or denial of provider and subscriber or enrollee claims, including those telemedicine services, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, covered by the plan. Except as provided in Section 1371, a procedure meeting the requirements of Subchapter G of the regulations (29 C.F.R. Part 2560) under Public Law 93-406 (88 Stats. 829-1035, 29 U.S.C. Secs. 1001 et seq.) shall satisfy this requirement.

(b) In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the following:

(1) The financial soundness of the plan's arrangements for health care services and the schedule of rates and charges used by the plan.

(2) The adequacy of working capital.

(3) Agreements with providers for the provision of health care services.

(c) For the purposes of this section, ''covered health care services'' means health care services provided under all plan contracts.

SEC. 123. Section 1376 of the Health and Safety Code is amended to read:

1376. (a) No plan shall conduct any activity regulated by this chapter in contravention of such rules and regulations as the director may prescribe as necessary or appropriate in the public interest or for the protection of plans, subscribers, and enrollees to provide safeguards with respect to the financial responsibility of plans. Such rules and regulations may require a minimum capital or net worth, limitations on indebtedness, procedures for the handling of funds or assets, including segregation of funds, assets and net worth, the maintenance of appropriate insurance and a fidelity bond and the

maintenance of a surety bond in an amount not exceeding fifty thousand dollars ($50,000).

(b) The surety bond referred to in subdivision (a) shall be conditioned upon compliance by the licensee with the provisions of this chapter and the rules and regulations adopted pursuant to this chapter and orders issued under this chapter. Every surety bond shall provide that no suit may be maintained to enforce any liability thereon unless brought within two years after the act upon which such suit is based.

(c) For purposes of computing any minimum capital requirement which may be prescribed by the rules and regulations of the director under subdivision (a), any operating cost assistance or direct loan made to a plan by the United States Department of Health and Human Services pursuant to Public Law 93-222, as amended, may be treated as a subordinated loan, notwithstanding any express terms thereof to the contrary.

(d) Each solicitor and solicitor firm shall handle funds received for the account of plans, subscribers, or groups in accordance with such rules as the director may adopt pursuant to this subdivision.

(e) The director may, by regulation, designate requirements of this section or regulations adopted pursuant to this section, from which public entities and political subdivisions of the state shall be exempt.

SEC. 124. Section 1377 of the Health and Safety Code is amended to read:

1377. (a) Every plan which reimburses providers of health care services that do not contract in writing with the plan to provide health care services, or which reimburses its subscribers or enrollees for costs incurred in having received health care services from providers that do not contract in writing with the plan, in an amount which exceeds 10 percent of its total costs for health care services for the immediately preceding six months, shall comply with the requirements set forth in either paragraph (1) or (2):

(1) (A) Place with the director, or with any organization or trustee acceptable to the director through which a custodial or controlled account is maintained, a noncontracting provider insolvency deposit consisting of cash or securities that are acceptable to the director that at all times have a fair market value in an amount at least equal to 120 percent of the sum of the following:

(i) All claims for noncontracting provider services received for reimbursement, but not yet processed.

(ii) All claims for noncontracting provider services denied for reimbursement during the previous 45 days.

(iii) All claims for noncontracting provider services approved for reimbursement, but not yet paid.

(iv) An estimate of claims for noncontracting provider services incurred, but not reported.

(B) Each plan licensed pursuant to this chapter prior to January 1, 1991, shall, upon that date, make a deposit of 50 percent of the amount required by subparagraph (A), and shall maintain additional cash or cash equivalents as defined by rule of the director, in the amount of 50 percent of the amount required by subparagraph (A), and shall make a deposit of 100 percent of the amount required by subparagraph (A) by January 1, 1992.

(C) The amount of the deposit shall be reasonably estimated as of the first day of the month and maintained for the remainder of the month.

(D) The deposit required by this paragraph is in addition to the deposit that may be required by rule of the director and is an allowable asset of the plan in the determination of tangible net equity as defined in subdivision (b) of Section 1300.76 of Title 10 of the California Code of Regulations. All income from the deposit shall be an asset of the plan and may be withdrawn by the plan at any time.

(E) A health care service plan that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this paragraph is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the director, but approval shall not be required for the withdrawal of earned income.

(F) The deposit required under this section is in trust and may be used only as provided by this section. The director or, if a receiver has been appointed, the receiver shall use the deposit of an insolvent health care service plan, as defined in Sections 1394.7 and 1394.8, for payment of covered claims for services rendered by noncontracting providers under circumstances covered by the plan. All claims determined by the director or receiver, in his or her discretion, to be eligible for reimbursement under this section shall be paid on a pro rata basis based on assets available from the deposit to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health care service plan. The director may also use the deposit of an insolvent health care service plan for payment of any administrative costs associated with the administration of this section. The department, the director, and any employee of the department shall not be liable, as provided by Section 820.2 of the Government Code, for an injury resulting from an exercise of discretion pursuant to this section. Nothing in this section shall be construed to provide immunity for the acts of a receiver, except when the director is acting as a receiver.

(G) The director may, by regulation, prescribe the time, manner, and form for filing claims.

(H) The director may permit a plan to meet a portion of this requirement by a deposit of tangible assets acceptable to the director, the fair market value of which shall be determined on at least an annual basis by the director. The plan shall bear the cost of any appraisal or valuations required hereunder by the director.

(2) Maintain adequate insurance, or a guaranty arrangement approved in writing by the director, to pay for any loss to providers, subscribers, or enrollees claiming reimbursement due to the insolvency of the plan.

(b) Whenever the reimbursements described in this section exceed 10 percent of the plan's total costs for health care services over the immediately preceding six months, the plan shall file a written report with the director containing the information necessary to determine compliance with subdivision (a) no later than 30 business days from the first day of the month. Upon an adequate showing by the plan that the requirements of this section should be waived or reduced, the director may waive or reduce these requirements to an amount as the director deems sufficient to protect subscribers and enrollees of the plan consistent with the intent and purpose of this chapter.

(c) Every plan which reimburses providers of health care service on a fee-for-services basis; or which directly reimburses its subscribers or enrollees, to an extent exceeding 10 percent of its total payments for health care services, shall estimate and record in the books of account a liability for incurred and unreported claims. Upon a determination by the director that the estimate is inadequate, the director may require the plan to increase its estimate of incurred and unreported claims. Every plan shall promptly report to the director whenever these reimbursables exceed 10 percent of its total expenditures for health care services.

As used herein, the term ''fee-for-services'' refers to the situation where the amount of reimbursement paid by the plan to providers of service is determined by the amount and type of service rendered by the provider of service.

(d) In the event an insolvent plan covered by this section fails to pay a noncontracting provider sums for covered services owed, the provider shall first look to the uncovered expenditures insolvency deposit or the insurance or guaranty arrangement maintained by the plan for payment. When a plan becomes insolvent, in no event shall a noncontracting provider, or agent, trustee, or assignee thereof, attempt to collect from the subscriber or enrollee sums owed for covered services by the plan or maintain any action at law against a subscriber or enrollee to collect sums owed by the plan for covered services without having first attempted to obtain reimbursement from the plan.

SEC. 125. Section 1380 of the Health and Safety Code is amended to read:

1380. (a) The department shall conduct periodically an onsite medical survey of the health delivery system of each plan. The survey shall include a review of the procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees.

(b) The survey shall be conducted by a panel of qualified health professionals experienced in evaluating the delivery of prepaid health care. The department shall be authorized to contract with professional organizations or outside personnel to conduct medical surveys and these contracts shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. These organizations or personnel shall have demonstrated the ability to objectively evaluate the delivery of health care by plans or health maintenance organizations.

(c) Surveys performed pursuant to this section shall be conducted as often as deemed necessary by the director to assure the protection of subscribers and enrollees, but not less frequently than once every three years. Nothing in this section shall be construed to require the survey team to visit each clinic, hospital office, or facility of the plan. To avoid duplication, the director shall employ, but is not bound by, the following:

(1) For hospital-based health care service plans, to the extent necessary to satisfy the requirements of this section, the findings of inspections conducted pursuant to Section 1279.

(2) For health care service plans contracting with the State Department of Health Services pursuant to the Waxman-Duffy Prepaid Health Plan Act, the findings of reviews conducted pursuant to Section 14456 of the Welfare and Institutions Code.

(3) To the extent feasible, reviews of providers conducted by professional standards review organizations, and surveys and audits conducted by other governmental entities.

(d) Nothing in this section shall be construed to require the medical survey team to review peer review proceedings and records conducted and compiled under Section 1370 or medical records. However, the director shall be authorized to require onsite review of these peer review proceedings and records or medical records where necessary to determine that quality health care is being delivered to subscribers and enrollees. Where medical record review is authorized, the survey team shall insure that the confidentiality of physician-patient relationship is safeguarded in accordance with existing law and neither the survey team nor the director or the director’s staff may be compelled to disclose this information except in accordance with the physician-patient relationship. The director shall ensure that the confidentiality of the peer review proceedings

and records is maintained. The disclosure of the peer review proceedings and records to the director or the medical survey team shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1.

(e) The procedures and standards utilized by the survey team shall be made available to the plans prior to the conducting of medical surveys.

(f) During the survey the members of the survey team shall examine the complaint files kept by the plan pursuant to Section 1368. The survey report issued pursuant to subdivision (i) shall include a discussion of the plan's record for handling complaints.

(g) During the survey the members of the survey team shall offer such advice and assistance to the plan as deemed appropriate.

(h) (1) Survey results shall be publicly reported by the director as quickly as possible but no later than 180 days following the completion of the survey unless the director determines, in his or her discretion, that additional time is reasonably necessary to fully and fairly report the survey results. The director shall provide the plan with an overview of survey findings and notify the plan of deficiencies found by the survey team at least 90 days prior to the release of the public report.

(2) Reports on all surveys, deficiencies, and correction plans shall be open to public inspection except that no surveys, deficiencies, or correction plans shall be made public unless the plan has had an opportunity to review the report and file a response within 45 days of the date that the department provided the report to the plan. After reviewing the plan's response, the director shall issue a final report that excludes any survey information and legal findings and conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan by the time of the director's receipt of the plan's 45-day response, and describes remedial actions for deficiencies requiring longer periods to the remedy required by the director or proposed by the plan.

(3) The final report shall not include a description of ''acceptable'' or of ''compliance'' for any uncorrected deficiency.

(4) Upon making the final report available to the public, a single copy of a summary of the final report's findings shall be made available free of charge by the department to members of the public, upon request. Additional copies of the summary may be provided at the department's cost. The summary shall include a discussion of compliance efforts, corrected deficiencies, and proposed remedial actions.

(5) If requested by the plan, the director shall append the plan's response to the final report issued pursuant to paragraph (2), and shall append to the summary issued pursuant to paragraph (4) a brief

statement provided by the plan summarizing its response to the report. The plan may modify its response or statement at any time and provide modified copies to the department for public distribution no later than 10 days from the date of notification from the department that the final report will be made available to the public. The plan may file an addendum to its response or statement at any time after the final report has been made available to the public. The addendum to the response or statement shall also be made available to the public.

(6) Any information determined by the director to be confidential pursuant to statutes relating to the disclosure of records, including the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), shall not be made public.

(i) (1) The director shall give the plan a reasonable time to correct deficiencies. Failure on the part of the plan to comply to the director's satisfaction shall constitute cause for disciplinary action against the plan.

(2) No later than 18 months following release of the final report required by subdivision (h), the department shall conduct a follow-up review to determine and report on the status of the plan's efforts to correct deficiencies. The department's follow-up report shall identify any deficiencies reported pursuant to subdivision (h) that have not been corrected to the satisfaction of the director.

(3) If requested by the plan, the director shall append the plan's response to the follow-up report issued pursuant to paragraph (2). The plan may modify its response at any time and provide modified copies to the department for public distribution no later than 10 days from the date of notification from the department that the follow-up report will be made available to the public. The plan may file an addendum to its response at any time after the follow-up report has been made available to the public. The addendum to the response or statement shall also be made available to the public.

(j) The director shall provide to the plan and to the executive officer of the Board of Dental Examiners a copy of information relating to the quality of care of any licensed dental provider contained in any report described in subdivisions (h) and (i) that, in the judgment of the director, indicates clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment. Any confidential information provided by the director shall not be made public pursuant to this subdivision. Notwithstanding any other provision of law, the disclosure of this information to the plan and to the executive officer shall not operate as a waiver of confidentiality. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the State of California, the Department of Managed Care, the Director of the Department of Managed Care, the Board

of Dental Examiners, or any officer, agent, employee, consultant, or contractor of the state or the department or the board for the release of any false or unauthorized information pursuant to this section, unless the release of that information is made with knowledge and malice.

(k) Nothing in this section shall be construed as affecting the director's authority pursuant to Article 7 (commencing with Section 1386) or Article 8 (commencing with Section 1390) of this chapter.

SEC. 126. Section 1380.1 of the Health and Safety Code is amended to read:

1380.1. (a) (1) With the department as the lead agency, the department and the State Department of Health Services shall convene a working group for the purpose of developing standards for quality audits of providers that provide services to enrollees pursuant to contracts governed by this chapter.

(2) The working group shall include, but not be limited to, representatives of health care service plans, consumer organizations, public and private purchasers of health care, and providers, including medical groups, independent practice associations, and health facilities.

(3) The working group shall be comprised so that a balance of perspectives of providers, plans, purchasers of health care, and consumers can reasonably be expected to be represented.

(4) The department may consult with the National Commission on Quality Assurance, the federal Health Care Financing Authority, and other organizations that have worked toward defining quality standards.

(5) The department shall consult with the State Department of Health Services on the implementation of this section.

(6) The Legislature recognizes that streamlining audits, and defining quality standards, are best achieved with consideration of federal regulatory and third party auditing standards.

(b) To the extent feasible, the goals of this working group shall include, but not be limited to, all of the following:

(1) Recommending ways to reduce duplicative audits of providers by health plans.

(2) Developing a core set of health care quality standards that can serve as baseline requirements for meeting audit standards for contracts governed by this chapter.

(3) Recommending data collection methods and processes that can result in better coordination of health care quality audits, lessen the burden on providers, and maintain high quality standards for providers.

(4) Developing recommendations as to how health care service plans can best access quality information about providers in order to ensure higher quality standards than those core standards identified by the working group.

(5) Recommending standards for determining appropriate nonprofit organizations to conduct audits pursuant to the standards developed in this section.

(6) Determining how the results of quality audits shall be made available to the public.

(c) The department shall report to the Governor, the Department of Managed Care, the State Department of Health Services, and the appropriate committees of the Legislature, on or before January 1, 2000, its findings and recommendations pursuant to this section.

SEC. 127. Section 1380.3 of the Health and Safety Code is amended to read:

1380.3. Notwithstanding Section 1380, any plan that provides services solely to Medi-Cal beneficiaries pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall not be subject to the requirements of Section 1380 upon the submission to the director of the medical survey audit for the same period conducted by the State Department of Health Services as part of the Medi-Cal contracting process, unless the director determines that an additional medical survey audit is required.

SEC. 128. Section 1381 of the Health and Safety Code is amended to read:

1381. (a) All records, books, and papers of a plan, management company, solicitor, solicitor firm, and any provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm shall be open to inspection during normal business hours by the director.

(b) To the extent feasible, all such records, books, and papers described in subdivision (a) shall be located in this state. In examining such records outside this state, the director shall consider the cost to the plan, consistent with the effectiveness of the director's examination, and may upon reasonable notice require that such records, books and papers, or a specified portion thereof, be made available for examination in this state, or that a true and accurate copy of such records, books and papers, or a specified portion thereof, be furnished to the director.

SEC. 129. Section 1382 of the Health and Safety Code is amended to read:

1382. (a) The director shall conduct an examination of the fiscal and administrative affairs of any health care service plan, and each person with whom the plan has made arrangements for administrative, management, or financial services, as often as deemed necessary to protect the interest of subscribers or enrollees, but not less frequently than once every five years.

(b) The expense of conducting any additional or nonroutine examinations pursuant to this section, and the expense of conducting any additional or nonroutine medical surveys pursuant to Section

1380 shall be charged against the plan being examined or surveyed. The amount shall include the actual salaries or compensation paid to the persons making the examination or survey, the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the director. In determining the cost of examinations or surveys, the director may use the estimated average hourly cost for all persons performing examinations or surveys of plans for the fiscal year. The amount charged shall be remitted by the plan to the director. If recovery of these costs cannot be made from the plan, these costs may be added to, but subject to the limitation of, the assessment provided for in subdivision (b) of Section 1356.

(c) Reports of all examinations shall be open to public inspection, except that no examination shall be made public, unless the plan has had an opportunity to review the examination report and file a statement or response within 45 days of the date that the department provided the report to the plan. After reviewing the plan's response, the director shall issue a final report that excludes any survey information, legal findings, or conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan on or before the time the director receives the plan's response, and describes remedial actions for deficiencies requiring longer periods for the remedy required by the director or proposed by the plan.

(d) If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public.

(e) Notwithstanding subdivision (c), any health care service plan that contracts with the State Department of Health Services to provide service to Medi-Cal beneficiaries pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code may make a written request to the director to permit the State Department of Health Services to review its examination report.

(f) Upon receipt of the written request described in subdivision (e), the director may, consistent with Section 6254.5 of the Government Code, permit the State Department of Health Services to review the plan's examination report.

(g) Nothing in this section shall be construed as affecting the director's authority pursuant to Article 7 (commencing with Section 1386) or Article 8 (commencing with Section 1390).

SEC. 130. Section 1384 of the Health and Safety Code is amended to read:

1384. (a) Within 90 days after receipt of a request from the director, a plan or other person subject to this chapter shall submit to the director an audit report containing audited financial statements covering the 12-calendar months next preceding the month of receipt of the request, or another period as the director may require.

(b) On or before 105 days after the date of a notice of surrender or order of revocation, a plan shall file with the director a closing audit report containing audited financial statements. The reporting period for the closing audit report shall be the 12-month period preceding the date of the notice of surrender or order of revocation, or for another period as the director may specify. This report shall include other relevant information as specified by rule of the director. The director shall not consent to a surrender and an order of revocation shall not be considered final until the closing audit report has been filed with the director and all concerns raised by the director therefrom have been resolved by the plan, as determined by the director. For good cause, the director may waive the requirement of a closing audit report.

(c) Except as otherwise provided in this subdivision, each plan shall submit financial statements prepared as of the close of its fiscal year within 120 days after the close of the fiscal year. The financial statements referred to in this subdivision and in subdivisions (a) and (b) of this section shall be accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant. The audits shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the director. However, financial statements from public entities or political subdivisions of the state whose audits are conducted by a county grand jury shall be submitted within 180 days after the close of the fiscal year and need not include a report, certificate, or opinion by an independent certified public accountant or an independent public accountant, and the audit shall be conducted in accordance with governmental auditing standards.

(d) A plan, solicitor, or solicitor firm shall make any special reports to the director as the director may from time to time require.

(e) For good cause and upon written request, the director may extend the time for compliance with subdivisions (a), (b), and (h) of this section.

(f) A plan, solicitor, or solicitor firm shall, when requested by the director, for good cause, submit its unaudited financial statement, prepared in accordance with generally accepted accounting principles and consisting of at least a balance sheet and statement of income as of the date and for the period specified by the director. The director may require the submission of these reports on a monthly or other periodic basis.

(g) If the report, certificate, or opinion of the independent accountant referred to in subdivision (c) is in any way qualified, the director may require the plan to take any action as the director deems appropriate to permit an independent accountant to remove the qualification from the report, certificate, or opinion.

(h) The director may reject any financial statement, report, certificate, or opinion filed pursuant to this section by notifying the plan, solicitor, or solicitor firm required to make this filing of its rejection and the cause thereof. Within 30 days after the receipt of the notice, the person shall correct the deficiency, and the failure so to do shall be deemed a violation of this chapter. The director shall retain a copy of all filings so rejected.

(i) The director may make rules and regulations specifying the form and content of the reports and financial statements referred to in this section, and may require that these reports and financial statements be verified by the plan or other person subject to this chapter in a manner as the director may prescribe.

SEC. 131. Section 1385 of the Health and Safety Code is amended to read:

1385. Each plan, solicitor firm, and solicitor shall keep and maintain current such books of account and other records as the director may by rule require for the purposes of this chapter. Every plan shall require all providers who contract with the plan to report to the plan in writing all surcharge and copayment moneys paid by subscribers and enrollees directly to such providers, unless the director expressly approves otherwise.

SEC. 132. Section 1386 of the Health and Safety Code is amended to read:

1386. (a) The director may, after appropriate notice and opportunity for a hearing, by order, suspend or revoke any license issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

(2) The plan has issued, or permits others to use, evidence of coverage or uses a schedule of charges for health care services which do not comply with those published in the latest evidence of coverage found unobjectionable by the director.

(3) The health care service plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage. This subdivision shall not apply to specialized health care service plan contracts.

(4) The plan is no longer able to meet the standards set forth in Article 5 (commencing with Section 1367).

(5) The continued operation of the plan will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.

(7) The plan has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.

(8) The plan has permitted, or aided or abetted any violation by an employee or contractor who is a holder of any certificate, license, permit, registration or exemption issued pursuant to the Business and Professions Code, or the Health and Safety Code which would constitute grounds for discipline against the certificate, license, permit, registration, or exemption.

(9) The plan has aided or abetted or permitted the commission of any illegal act.

(10) The engagement of a person as an officer, director, employee, associate, or provider of the plan contrary to the provisions of an order issued by the director pursuant to subdivision (c) of this section or subdivision (d) of Section 1388.

(11) The engagement of a person as a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the director pursuant to Section 1388.

(12) The plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with this chapter. The director may revoke or deny a license hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

(13) The plan violates Section 510, 2056, or 2056.1 of the Business and Professions Code.

(14) The plan has been subject to a final disciplinary action taken by this state, another state, an agency of the federal government, or another country, for any act or omission that would constitute a violation of this chapter.

(c) (1) The director may prohibit any person from serving as an officer, director, employee, associate, or provider of any plan or solicitor firm, or of any management company of any plan, or as a solicitor, if either of the following applies:

(A) The prohibition is in the public interest and the person has committed, caused, participated in, or had knowledge of a violation of this chapter by a plan, management company, or solicitor firm.

(B) The person was an officer, director, employee, associate, or provider of a plan or of a management company or solicitor firm of any plan whose license has been suspended or revoked pursuant to this section and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a plan under this section or may constitute a separate proceeding, subject in either case to, subdivision (d).

(d) A proceeding under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

SEC. 133. Section 1387 of the Health and Safety Code is amended to read:

1387. (a) Any person who violates any provision of this chapter, or who violates any rule or order adopted or issued pursuant to this chapter, shall be liable for a civil penalty not to exceed two thousand five hundred dollars ($2,500) for each violation, which shall be assessed and recovered in a civil action brought in the name of the people of the State of California by the director in any court of competent jurisdiction.

(b) As applied to the civil penalties for acts in violation of this chapter, the remedies provided by this section and by other sections of this chapter are not exclusive, and may be sought and employed in any combination to enforce this chapter.

(c) No action shall be maintained to enforce any liability created under subdivision (a), unless brought before the expiration of four years after the act or transaction constituting the violation.

SEC. 134. Section 1388 of the Health and Safety Code is amended to read:

1388. (a) The director may, after appropriate notice and opportunity for hearing, by order, censure a person acting as a solicitor or solicitor firm, or suspend for a period not exceeding 24 months or bar a person from operating as a solicitor or solicitor firm, or assess administrative penalties against a person acting as a solicitor or solicitor firm if the director determines that the person has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The continued operation of the solicitor or solicitor firm in a manner that may constitute a substantial risk to a plan or subscribers and enrollees.

(2) The solicitor or solicitor firm has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to the chapter, or any order issued by the director pursuant to this chapter.

(3) The solicitor or solicitor firm has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.

(4) The engagement of a person as an officer, director, employee, or associate of the solicitor firm contrary to the provisions of an order issued by the director pursuant to subdivision (d) of this section or subdivision (c) of Section 1386.

(5) The solicitor or solicitor firm, or its management company, or any other affiliate of the solicitor firm, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in that solicitor firm, management company, or affiliate, has been convicted or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with the provisions of this chapter. The director may issue an order hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

(c) The director shall notify plans of any order issued pursuant to subdivision (a) which suspends or bars a person from engaging in operations as a solicitor or solicitor firm. It shall be unlawful for any plan, after receipt of notice of the order, to receive any new subscribers or enrollees through that person or to otherwise utilize any solicitation services of that person in violation thereof.

(d) (1) The director may prohibit any person from serving as an officer, director, employee, or associate of any plan or solicitor firm, or as a solicitor, if that person was an officer, director, employee, or associate of a solicitor firm that has been the subject of an order of suspension or bar from engaging in operations as a solicitor firm pursuant to this section and that person had knowledge of, or participated in, any of the prohibited acts for which the order was issued.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a solicitor firm under this section or may constitute a separate proceeding, subject in either case to subdivision (e).

(e) A proceeding for the issuance of an order under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

SEC. 135. Section 1389 of the Health and Safety Code is amended to read:

1389. (a) A person whose license has been revoked, or suspended for more than one year, may petition the director to reinstate the license as provided by Section 11522 of the Government Code. No petition may be considered if the petitioner is under criminal sentence for a violation of this chapter, or any offense which would constitute grounds for discipline, or denial of licensure under this chapter, including any period of probation or parole.

(b) A person who is barred, or suspended for more than one year, from acting as a solicitor or solicitor firm pursuant to Section 1388, or who is subject to an order, pursuant to subdivision (c) of Section 1386 or subdivision (d) of Section 1388, which by its terms is effective for more than one year, may petition the director to reduce by order such penalty in a manner generally consistent with the provisions of Section 11522 of the Government Code. No petition may be considered if the petitioner is under criminal sentence for a violation of this chapter, or any offense which would constitute grounds for discipline under this chapter, including any period of probation or parole.

(c) The petition for restoration shall be in the form prescribed by the director and the director may condition the granting of such petition upon such additional information and undertakings as the director may require in order to determine whether such person, if restored, would engage in business in full compliance with the objectives and provisions of this chapter and the rules and regulations adopted by the director pursuant to this chapter.

(d) The director may, by rule, prescribe a fee not to exceed five hundred dollars ($500) for the filing of a petition for restoration pursuant to this section. In addition, the director may condition the granting of such a petition to a plan upon payment of the assessment due and unpaid pursuant to subdivision (b) of Section 1356 as of the 15th day of December occurring within the preceding 12-calendar months and, if the plan’s suspension or revocation was in effect for more than 12 months, upon the filing of a new plan application and the payment of the fee prescribed by subdivision (a) of Section 1356.

SEC. 136. Section 1389.1 of the Health and Safety Code is amended to read:

1389.1. (a) The director shall not approve any plan contract unless the director finds that the application conforms to both of the following requirements:

(1) All applications for coverage which include health-related questions shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions related to an applicant's health shall be based on medical information that is reasonable and necessary for medical underwriting purposes. The application shall include a prominently displayed notice that shall read:

''California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.''

(b) Nothing in this section shall authorize the director to establish or require a single or standard application form for application questions.

SEC. 137. Section 1389.2 of the Health and Safety Code is amended to read:

1389.2. At the request of the director, a health care service plan shall provide a written statement of the actuarial basis for any medical underwriting decision on any application form, or contract issued or delivered to, or denied a resident of this state.

SEC. 138. Section 1391 of the Health and Safety Code is amended to read:

1391. (a) (1) The director may issue an order directing a plan, solicitor firm, or any representative thereof, a solicitor, or any other person to cease and desist from engaging in any act or practice in violation of the provisions of this chapter, any rule adopted pursuant to this chapter, or any order issued by the director pursuant to this chapter.

(2) If the plan, solicitor firm, or any representative thereof, or solicitor, or any other person fails to file a written request for a hearing within 30 days from the date of service of the order, the order shall be deemed a final order of the director and shall not be subject to review by any court or agency, notwithstanding subdivision (b) of Section 1397.

(b) If a timely request for a hearing is made by a licensed plan, the request shall automatically stay the effect of the order only to the extent that the order requires the cessation of operation of the plan or prohibits acceptance of new members by the plan or both. However, no automatic stay shall be issued if any examination or inspection of the plan performed by the director discloses, or reports or documents submitted to the director by the plan on their face show, that the plan is in violation of any fiscal requirement of this chapter or in violation of any requirement of Section 1384 or 1385. In the event of an automatic stay, only that portion of the order requiring cessation of operation or prohibiting enrollment shall be stayed and all other portions of the order shall remain effective. If a hearing is held, and a finding is made that the health or safety of the members and potential members of the plan might be adversely affected by its continued operation, the stay shall be terminated. This

finding shall be made, if at all, not later than 30 days after the date of the hearing.

(c) If a timely request for a hearing is made by an unlicensed plan, the director may stay the effect of the order to the extent that the order requires the cessation of operation of the plan or prohibits acceptance of new members by the plan, for that period and subject to those conditions that the director may require, upon a determination by the director that the action would be in the public interest.

SEC. 139. Section 1391.5 is added to the Health and Safety Code, to read:

1391.5. (a) If, after examination or investigation, the director has reasonable grounds to believe that irreparable loss and injury to the plan's enrollee or enrollees occurred or may occur unless the director acts immediately, the director may, by written order, addressed to that person, order the discontinuance of the unsafe or injurious practice. The order shall become effective immediately, but shall not become final except in accordance with this section.

(b) No order issued pursuant to this section shall become final except after notice to the affected person of the director's intention to make the order final and of the reasons for the finding. The director shall also notify that person that upon receiving a request for hearing by the plan, the matter shall be set for hearing to commence with 15 business days after receipt of the request, unless that person consents to have the hearing commence at a later date.

(c) If no hearing is requested within 15 days after the mailing or service of the required notice, and none is ordered by the director, the order shall become final on the 15th day without a hearing and shall not be subject to review by any court or agency notwithstanding subdivision (b) of Section 1397.

(d) If a hearing is requested or ordered, it shall be held in accordance with the provisions of the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and the director shall have all of the powers granted under that act.

(e) If, upon conclusion of the hearing, it appears to the director that the affected person has conducted business in an unsafe or injurious manner, the director shall make the order of discontinuance final.

(f) For purposes of this section, 'person'' includes any plan, solicitor firm, or any representative thereof, a solicitor, or any other person defined in subdivision (j) of Section 1345.

SEC. 140. Section 1392 of the Health and Safety Code is amended to read:

1392. (a) (1) Whenever it appears to the director that any person has engaged, or is about to engage, in any act or practice constituting a violation of any provision of this chapter, any rule

adopted pursuant to this chapter, or any order issued pursuant to this chapter, the director may bring an action in superior court, or the director may request the Attorney General to bring an action to enjoin these acts or practices or to enforce compliance with this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter, or to obtain any other equitable relief.

(2) If the director determines that it is in the public interest, the director may include in any action authorized by paragraph (1) a claim for any ancillary or equitable relief and the court shall have jurisdiction to award this additional relief.

(3) Upon a proper showing, a permanent or preliminary injunction, restraining order, writ of mandate, or other relief shall be granted, and a receiver, monitor, conservator, or other designated fiduciary or officer of the court may be appointed for the defendant or the defendant's assets.

(b) A receiver, monitor, conservator, or other designated fiduciary, or officer of the court appointed by the superior court pursuant to this section may, with the approval of the court, exercise any or all of the powers of the defendant's officers, directors, partners, or trustees, or any other person who exercises similar powers and performs similar duties, including the filing of a petition for bankruptcy. No action at law or in equity may be maintained by any party against the director, or a receiver, monitor, conservator, or other designated fiduciary or officer of the court by reason of their exercising these powers or performing these duties pursuant to the order of, or with the approval of, the superior court.

SEC. 141. Section 1393 of the Health and Safety Code is amended to read:

1393. (a) The superior court of the county in which is located the principal office of the plan in this state shall, upon the filing by the director of a verified application showing any of the conditions enumerated in Section 1386 to exist, issue its order vesting title to all of the assets of the plan, wherever situated, in the director or the director's successor in office, in his or her official capacity as such, and direct the director to take possession of all of its books, records, property, real and personal, and assets, and to conduct, as conservator, the business or portion of the business of the person as may seem appropriate to the director, and enjoining the person and its officers, directors, agents, servants, and employees from the transaction of its business or disposition of its property until the further order of the court.

(b) Whenever it appears to the director that irreparable loss and injury to the property and business of the plan or to the plan's enrollees has occurred or may occur unless the director acts immediately, the director, without notice and before applying to the court for any order, may take possession of the property, business,

books, records, and accounts of the plan, and of the offices and premises occupied by it for the transaction of its business, and retain possession until returned to the plan or until further order of the director or subject to an order of the court. Any person having possession of and refusing to deliver any of the books, records, or assets of a plan against which a seizure order has been issued by the director, shall be guilty of a misdemeanor and punishable by a fine not exceeding ten thousand dollars ($10,000) or imprisonment not exceeding one year, or both the fine and imprisonment. Whenever the director has taken possession of any plan pursuant to this subdivision, the owners, officers, and directors of the plan may apply to the superior court in the county in which the principal office of the plan is located, within 10 days after the taking, to enjoin further proceedings. The court, after citing the director to show cause why further proceedings should not be enjoined, and after a hearing and a determination of the facts upon the merits, may do any of the following:

(1) Dismiss the application after confirming the director's authority to take possession of all of the plan's books, records, property, real and personal, and assets, and to conduct, as conservator, the business or portion of the business as the director may deem appropriate, and enjoining the owners, officers, and directors, and their agents and employees, from the transaction of plan business or disposition of plan property until the further order of the court.

(2) Enjoin the director from further proceedings and direct the director to surrender the property and business to the plan.

(3) Make any further order as may be just.

(c) If any facts occur that would entitle the director to take possession of the property, business, and assets of the plan, the director may appoint a conservator over the plan and require any bond of the conservator as the director deems proper. The conservator, under the direction of the director, shall take possession of the property, business, and assets of the plan pending further disposition of its business. The conservator shall retain possession until the property, business, and assets of the plan are returned to the plan, or until further order of the director, except that the conservator shall be able to pay necessary costs of the ongoing operation without formal order of the director. Whenever the director has taken possession of any plan pursuant to subdivision (b), the director shall, within 10 days after the taking, apply to the superior court in the county in which the principal office of the plan is located for an order confirming the director's appointment of the conservator. The order may be given after a hearing upon notice that the court prescribes.

(d) (1) Subject to the other provisions of this section, a conservator, while in possession of the property, business, and assets

of a plan, has the same powers and rights, and is subject to the same duties and obligations, as the director under the same circumstances, and during this time, the rights of a plan and of all persons with respect to the plan are the same as if the director had taken possession of the property, business, and assets of the plan, for the purpose of carrying out the conservatorship.

(2) Subject to the other provisions of this section, a conservator, while in possession of the property, business, and assets of a plan, shall have all of the rights, powers, and privileges of the plan, and its officers and directors, for the purpose of carrying out the conservatorship. All expenses of any conservatorship shall be paid from the assets of the plan, and shall be a lien on the plan which shall be prior to any other lien.

(3) No action at law or in equity may be maintained by any party against the director or a conservator by reason of their exercising or performing the privileges, powers, rights, duties, and obligations pursuant to the order, or with the approval, of the superior court.

(e) Upon appointing a conservator, the director shall cause to be made and completed, at the earliest possible date, an examination of the affairs of the plan as shall be necessary to inform the director as to the plan's financial condition.

(f) If the director becomes satisfied that it may be done safely and in the public interest, the director may terminate the conservatorship and permit the plan for which the conservator was appointed to resume its business under the direction of its board of directors, subject to any terms, conditions, restrictions, and limitations the director prescribes.

SEC. 142. Section 1393.5 of the Health and Safety Code is amended to read:

1393.5. (a) A person who violates Section 1349, or any person who directly or indirectly participates in the direction of the management or policies of the person in violation of Section 1349, including, but not limited to, any officer, director, partner, or other person occupying a principal management or supervisory position, shall be liable for civil penalties as follows:

(1) A sum not more than two thousand five hundred dollars ($2,500), and (2) a sum not exceeding five hundred dollars ($500) for each subscriber under an individual or group plan contract which was entered into or renewed while such person was in violation of Section 1349.

(b) The penalty specified in paragraph (2) of subdivision (a) shall be imposed only if one or more of the following occurs:

(1) The solicitation of the entry into or renewal of such contract, or of any subscription or enrollment thereunder, included the use by the plan or a representative of the plan of any advertising, evidence of coverage, or disclosure form which was untrue, misleading, or deceptive.

(2) The contract is not in compliance with this chapter, or the rules adopted pursuant to this chapter.

(3) The plan does not have a financially sound operation and adequate provision against the risk of insolvency.

(4) The plan has operated in violation of the provisions of subdivision (a), (b), (c), (d), or (e) of Section 1367.

(5) The plan has not complied with the provisions of Section 1379.

(c) The civil penalty may be assessed and recovered only in a civil action. The cause of action may be brought in the name of the people of the State of California by the Attorney General or the director, as determined by the director.

SEC. 143. Section 1393.6 of the Health and Safety Code is amended to read:

1393.6. For violations of Article 3.1 (commencing with Section 1357) and Article 3.15 (commencing with Section 1357.50), the commissioner may, after appropriate notice and opportunity for hearing, by order levy administrative penalties as follows:

(a) Any person, solicitor, or solicitor firm, other than a health care service plan, who willfully violates any provision of this chapter, or who willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two hundred fifty dollars ($250) for each first violation, and of not less than one thousand dollars ($1,000) and not more than two thousand five hundred dollars ($2,500) for each subsequent violation.

(b) Any health care service plan that willfully violates any provision of this chapter, or that willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

(c) The administrative penalties shall be paid to the Managed Care Fund.

(d) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

SEC. 144. Section 1394 of the Health and Safety Code is amended to read:

1394. The civil, criminal, and administrative remedies available to the director pursuant to this article are not exclusive, and may be sought and employed in any combination deemed advisable by the director to enforce the provisions of this chapter.

SEC. 145. Section 1394.1 of the Health and Safety Code is amended to read:

1394.1. Notwithstanding any other provision of law, the director may file a verified complaint for involuntary dissolution of a health care service plan on any one or more of the grounds specified in subdivision (b) of Section 1386. The complaint shall be filed in the superior court of the county where the principal executive office of the health care service plan is located or, if the principal executive office of the health care service plan is not located in this state, or the health care service plan has no such office, the County of Sacramento.

SEC. 146. Section 1394.3 of the Health and Safety Code is amended to read:

1394.3. Except as provided for in Section 1394.1, and 1394.2, the involuntary dissolution of a health care service plan shall be in accordance with either of the following:

(a) Chapter 18 (commencing with Section 1800) of Division 1 of Title 1 of the Corporations Code, if the plan is incorporated under the General Corporation Law.

(b) Chapter 15 (commencing with Section 8510) of Part 3 of Division 2 of Title 1 of the Corporations Code if the plan is incorporated under the Nonprofit Corporation Law.

SEC. 147. Section 1394.5 of the Health and Safety Code is amended to read:

1394.5. When any person, including any nonresident of this state, engages in conduct prohibited or made actionable by this chapter or any rule, regulation, or order adopted hereunder, whether or not the person has filed a power of attorney under subdivision (j) of Section 1351, and personal jurisdiction over the person cannot otherwise be obtained in this state, that conduct shall be considered equivalent to the appointment of the director or the director's successor in office to be the attorney in fact to receive any lawful process in any noncriminal suit, action, or proceeding against the person or the person's successor, executor, or administrator which arises out of that conduct and which is brought under this chapter or any rule, regulation, or order adopted hereunder, with the same force and validity as if personally served. Service may be made by leaving a copy of the process in the office of the director, but it is not effective unless the plaintiff or petitioner, who may be the director in a suit, action, or proceeding instituted by him or her, forthwith sends notice of the service and a copy of the process by registered or certified mail to the defendant or respondent at his or her last known address or takes other steps which are reasonably calculated to give actual notice, and in a court action, an affidavit of compliance with this section is filed in the case on or before the return day of the process, if any, or within such further time as the court allows. In the case of administrative orders issued by the director, the affidavit of

compliance need not be filed with the administrative tribunal unless the respondent requests a hearing.

SEC. 148. Section 1394.7 of the Health and Safety Code is amended to read:

1394.7. (a) As used in this section the following definitions shall apply:

(1) ''Health care service plan'' means any plan as defined in Section 1345, but this section does not apply to specialized health care service contracts.

(2) ''Carrier'' means a health care service plan, an insurer issuing group disability coverage which covers hospital, medical, or surgical expenses, a nonprofit hospital service plan, or any other entity responsible for either the payment of benefits or the provision of hospital, medical, and surgical benefits under a group contract.

(3) ''Insolvency'' means that the director has determined that the health care service plan is not financially able to provide health care services to its enrollees and (A) the director has taken an action pursuant to Section 1386, 1391, or 1399, or (B) an order requested by the director or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1.

(b) In the event of the insolvency of a health care service plan and upon order of the director, any health care service plan which the director determines to have sufficient health care delivery resources and sufficient financial and administrative capacity and that participated in the enrollment process with the insolvent health care service plan at the last regular open enrollment period of a group shall offer enrollees of the group in the insolvent health care service plan a 30-day enrollment period commencing upon the date specified by the director. Each health care service plan shall offer enrollees of the group in the insolvent health care service plan the same coverages and rates that it offered to enrollees of the group at the last regular open enrollment period of the group. Coverage shall be effective upon receipt by the successor plan of an application for enrollment by or on behalf of a subscriber or enrollee of the insolvent plan. The director shall send a notice of the insolvency of a health care service plan to the Insurance Commissioner.

(c) If no other carrier had been offered to groups enrolled in the insolvent health care service plan, or if the director determines that the other carriers do not include a sufficient number of health care service plans that have adequate health care delivery resources or the financial or administrative capacity to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health care service plan, then the director shall allocate equitably the insolvent health care service plan's group contracts for the groups, except for Medi-Cal contracts made pursuant to Section 14200 of the Welfare and Institutions Code, among all health care service plans which operate within at least a

portion of the service area of the insolvent health care service plan, taking into consideration the health care delivery resources and the financial and administrative capacity of each health care service plan. The director shall also have the authority to allocate equitably enrollees, except Medi-Cal enrollees, if he or she has been unable to successfully place them through the open enrollment procedure in subdivision (b). The director shall make every reasonable effort to allocate enrollees within 30 days of the insolvency of the plan, but not later than 45 days after insolvency. Each health care service plan to which a group or groups are so allocated shall offer the group or groups the health care service plan's coverage which is most similar to each group's coverage with the insolvent health care service plan, as determined by the director, at rates determined in accordance with the successor health care service plan's existing rating methodology. Coverage shall be effective upon the date specified by the director. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent health care service plan's contract or policy, no provision in a successor health care service plan's contract of coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding health care service plan shall be applied with respect to those enrollees validly covered under the insolvent health care service plan's contract or policy on the date of the assignment.

The State Department of Health Services shall have the authority to allocate Medi-Cal enrollees to other carriers with valid Medi-Cal contracts, which operate within the same service area of an insolvent Medi-Cal contractor and that have sufficient capacity to absorb the Medi-Cal enrollees allocated to them.

(d) The director shall also allocate equitably the insolvent health care service plan's nongroup enrollees among all health care service plans which operate within at least a portion of the service area of the insolvent health care service plan, taking into consideration the health care delivery resources or the financial and administrative capacity of each health care service plan. Each health care service plan to which nongroup enrollees are allocated shall offer the nongroup enrollees the health care service plan's most similar coverage for individual or conversion coverage, as determined by the director, taking into consideration his or her type of coverage in the insolvent health care service plan, at rates determined in accordance with the successor health care service plan's existing rating methodology. Coverage shall be effective upon the date specified by the director. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent health care service plan's contract or policy, no provision in a successor health care service plan's contract of coverage that would operate to

reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding health care service plan shall be applied with respect to those enrollees validly covered under the insolvent health care service plan's contract or policy on the date of the assignment. Successor health care service plans which do not offer direct nongroup enrollment may aggregate all allocated nongroup enrollees into one group for rating and coverage purposes.

(e) Contracting providers shall continue to provide services to enrollees of an insolvent plan until the effective date of an enrollee's coverage in a successor plan selected pursuant to either open enrollment or the allocation process but in no event for the period exceeding that required by their contract or 45 days in the case of allocation, whichever is greater; or for a period exceeding that required by their contract or 30 days in the case of open enrollment, whichever is greater.

(f) The failure to comply with an order under this section shall constitute a violation of this section.

SEC. 149. Section 1394.8 of the Health and Safety Code is amended to read:

1394.8. (a) As used in this section:

(1) ''Carrier'' means a specialized health care service plan, and any of the following entities which offer coverage comparable to the coverages offered by a specialized health care service plan: an insurer issuing group disability coverage; a nonprofit hospital service plan; or any other entity responsible for either the payment of benefits for or the provisions of services under a group contract.

(2) ''Insolvency'' means that the director has determined that the specialized health care service plan is not financially able to provide specialized health care services to its enrollees and (A) the director has taken an action pursuant to Section 1386, 1391, 1399, or (B) an order requested by the director or the Attorney General has been issued by the superior court under Sections 1392, 1393, or 1394.1.

(3) ''Specialized health care service plan'' means any plan authorized to issue only specialized health care service plan contracts as defined in Section 1345.

(b) In the event of the insolvency of a specialized health care service plan and upon order of the director, any specialized health care service plan which the director determines to have sufficient health care delivery resources and sufficient financial and administrative capacity and that participated in the enrollment process with the insolvent specialized health care service plan at the last regular open enrollment period of a group for the same type of specialized health care services shall offer enrollees of the group in the insolvent specialized health care service plan a 30-day enrollment period commencing upon the date specified by the director. Each specialized health care service plan shall offer enrollees of the group

in the insolvent specialized health care service plan the same specialized coverage and rates that it offered to the enrollees of the group at its last regular open enrollment period. Coverage shall be effective upon receipt by the successor plan of an application for enrollment by or on behalf of a subscriber or enrollee of the insolvent plan. The director shall send a notice of the insolvency of a specialized health care service plan to the Insurance Commissioner.

(c) If no other carrier for the same type of specialized health care services had been offered to some groups enrolled in the insolvent specialized health care service plan, or if the director determines that the other carriers do not include a sufficient number of specified health care service plans which have adequate health care delivery resources or the financial and administrative capacity to assure that the specialized health care services will be available and accessible to all of the group enrollees of the insolvent specialized health care service plan, then the director shall allocate equitably the insolvent specialized health care service plan's group contracts for the groups among all specialized health care service plans which offer the same type of specialized health care services as the insolvent plan and which operate within at least a portion of the service area of the insolvent specialized health care service plan, taking into consideration the health care delivery resources and the financial and administrative capacity of each specialized health care service plan. The director shall also have the authority to allocate equitable enrollees if he or she has been unable to successfully place them through the open enrollment procedure in subdivision (b). The director shall make every reasonable effort to allocate enrollees within 30 days of the insolvency of the plan, but not later than 45 days after insolvency. Each specialized health care service plan to which a group or groups is so allocated shall offer such group or groups the specialized health care service plan's coverage which is most similar to each group's coverage with the insolvent specialized health care service plan as determined by the director, at rates determined in accordance with the successor specialized health care service plan's existing rating methodology. Coverage shall be effective on a date specified by the director. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent specialized health care service plan's contract or policy, no provision in a successor specialized health care service plan's contract of coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding plan shall be applied with respect to those enrollees validly covered under the insolvent specialized health care service plan's contract or policy on the date of the assignment.

(d) The director shall also allocate equitably the insolvent specialized health care service plan's nongroup enrollees among all

specialized health care services which offer the same type of specialized health care services as the insolvent plan and which operate within at least a portion of the insolvent specialized health care service plan's service area, taking into consideration the health care delivery resources and the financial and administrative capacity of each specialized health care service plan. Each specialized health care service plan to which nongroup enrollees are allocated shall offer the nongroup enrollees the health care service plan's most similar coverage for individual or conversion coverage, as determined by the director, taking into consideration his or her type of coverage in the insolvent specialized health care service plan at rates determined in accordance with the successor specialized health care service plan's existing rating methodology. Coverage shall be effective on the date specified by the director. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent specialized health care service plan's contract or policy, no provision in a successor specialized health care service plan's contract of coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding plan shall be applied with respect to those enrollees validly covered under the insolvent specialized health care service plan's contract or policy on the date of the assignment. Successor specialized health care service plans which do not offer direct nongroup enrollment may aggregate all allocated nongroup enrollees into one group for rating and coverage purposes.

(e) Contracting providers shall continue to provide services to enrollees of an insolvent plan until the effective date of an enrollee's coverage in a successor plan selected pursuant to either open enrollment or the allocation process but in no event for the period exceeding that required by their contract or 45 days in the case of allocation, whichever is greater; or for a period exceeding that required by their contract or 30 days in the case of open enrollment, whichever is greater.

(f) Failure to comply with an order pursuant to this section shall constitute a violation of this section.

SEC. 150. Section 1395.5 of the Health and Safety Code is amended to read:

1395.5. (a) Except as provided in subdivisions (b) and (c), no contract that is issued, amended, renewed, or delivered on or after January 1, 1999, between a health care service plan, including a specialized health care service plan, and a provider shall contain provisions that prohibit, restrict, or limit the health care provider from advertising.

(b) Nothing in this section shall be construed to prohibit plans from establishing reasonable guidelines in connection with the activities regulated pursuant to this chapter, including those to

prevent advertising that is, in whole or in part, untrue, misleading, deceptive, or otherwise inconsistent with this chapter or the rules and regulations promulgated thereunder. For advertisements mentioning a provider's participation in a plan, nothing in this section shall be construed to prohibit plans from requiring each advertisement to contain a disclaimer to the effect that the provider's services may be covered for some, but not all, plan contracts, or that plan contracts may cover some, but not all, provider services.

(c) Nothing in this section is intended to prohibit provisions or agreements intended to protect service marks, trademarks, trade secrets, or other confidential information or property. If a health care provider participates on a provider panel or network as a result of a direct contractual arrangement with a health care service plan that, in turn, has entered into a direct contractual arrangement with another person or entity, pursuant to which enrollees, subscribers, insureds, and other beneficiaries of that other person or entity may receive covered services from the health care provider, then nothing in this section is intended to prohibit reasonable provisions or agreements in the direct contractual arrangement between the health care provider and the health care service plan that protect the name or trade name of the other person or entity or require that the health care provider obtain the consent of the health care service plan prior to the use of the name or trade name of the other person or entity in any advertising by the health care provider.

(d) Nothing in this section shall be construed to impair or impede the authority of the director to regulate advertising, disclosure, or solicitation pursuant to this chapter.

SEC. 151. Section 1396 of the Health and Safety Code is amended to read:

1396. It is unlawful for any person willfully to make any untrue statement of material fact in any application, notice, amendment, report, or other submission filed with the director under this chapter or the regulations adopted thereunder, or willfully to omit to state in any application, notice, or report any material fact which is required to be stated therein.

SEC. 152. Section 1397 of the Health and Safety Code is amended to read:

1397. (a) Whenever reference is made in this chapter to a hearing before or by the director, the hearing shall be held in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and the director shall have all of the powers granted under that act.

(b) Every final order, decision, license, or other official act of the director under this chapter is subject to judicial review in accordance with the law.

SEC. 153. Section 1397.5 of the Health and Safety Code is amended to read:

1397.5. (a) The director shall make and file annually with the Department of Managed Care as a public record, an aggregate summary of grievances against plans filed with the director by enrollees or subscribers. This summary shall include at least all of the following information:

(1) The total number of grievances filed.

(2) The types of grievances.

(b) The summary set forth in subdivision (a) shall include the following disclaimer:

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

(c) Nothing in this section shall require or authorize the disclosure of grievances filed with or received by the director and made confidential pursuant to any other provision of law including, but not limited to, the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). Nothing in this section shall affect any other provision of law including, but not limited to, the California Public Records Act and the Information Practices Act of 1977.

SEC. 154. Section 1397.6 of the Health and Safety Code is amended to read:

1397.6. The director may contract with necessary medical consultants to assist with the health care program. These contracts shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

SEC. 155. Section 1398 of the Health and Safety Code is amended to read:

1398. Neither the director nor any employee of the department shall be precluded from subscribing to or enrolling in any plan which is subject to the provisions of this chapter, subject to such rules as may be adopted hereunder or pursuant to other proper authority.

SEC. 156. Section 1399 of the Health and Safety Code is amended to read:

1399. (a) Surrender of a license as a health plan becomes effective 30 days after receipt of an application to surrender the license or within a shorter period of time as the director may determine, unless a revocation or suspension proceeding is pending when the application is filed or a proceeding to revoke or suspend or to impose conditions upon the surrender is instituted within 30 days

after the application is filed. If this proceeding is pending or instituted, surrender becomes effective at the time and upon the conditions as the director by order determines.

(b) If the director finds that any plan is no longer in existence, or has ceased to do business or has failed to initiate business activity as a licensee within six months after licensure, or cannot be located after reasonable search, the director may by order summarily revoke the license of the plan.

(c) The director may summarily suspend or revoke the license of a plan upon (1) failure to pay any fee required by this chapter within 15 days after notice by the director that the fee is due and unpaid, (2) failure to file any amendment or report required under this chapter within 15 days after notice by the director that the report is due, (3) failure to maintain any bond or insurance pursuant to Section 1376, (4) failure to maintain a deposit, insurance, or guaranty arrangement pursuant to Section 1377, or (5) failure to maintain a deposit pursuant to Section 1300.76.1 of Title 10 of the California Code of Regulations.

SEC. 157. Section 1399.1 of the Health and Safety Code is amended to read:

1399.1. (a) All orders and other actions taken by the Commissioner of Corporations pursuant to the authority contained in subdivision (c) of Section 1350 on or before September 30, 1977, and all administrative or judicial decisions or orders relating to the same and all conditions imposed upon the same remain in effect against a plan holding a transitional license.

(b) The Knox-Mills Health Plan Act as in effect prior to its repeal continues to govern all suits, actions, prosecutions or proceedings which are pending or which may be initiated under subdivision (c) of Section 1350 on the basis of facts or circumstances occurring on or before September 30, 1977.

SEC. 158. Section 1399.70 of the Health and Safety Code is amended to read:

1399.70. (a) In addition to the information required by subdivision (a) of Section 1399.73, a nonprofit health care service plan submitting an application to the director to restructure or convert its activities pursuant to this article shall submit to the director a copy of all of its original and amended articles of incorporation and bylaws, as well as a report summarizing the activities undertaken by the plan to meet its nonprofit obligations as directed by the director.

(b) The report required by this section shall include a summary of the following:

(1) The nature of public benefit or charitable activities undertaken by the plan.

(2) The expenditures incurred by the plan on these public benefit or charitable activities.

(3) The plan's procedure for avoiding conflicts of interest involving public benefit or charitable activities and a summary of any conflicts that have occurred and the manner in which they were resolved.

(c) The report required by this section shall also include a written plan that specifies on a projected basis the information required by subdivision (b) for the immediately following fiscal year.

(d) When requested by the director, the plan shall promptly supplement the report to include any additional information as the director deems necessary to ascertain whether the plan's assets are appropriately being used by the plan to meet its nonprofit obligations.

(e) For purposes of this article, a ''nonprofit health care service plan'' includes a plan formed under or subject to Part 2 (commencing with Section 5110) or Part 3 (commencing with Section 7110) of Division 2 of the Corporations Code.

SEC. 159. Section 1399.71 of the Health and Safety Code is amended to read:

1399.71. (a) Any nonprofit health care service plan that intends to restructure its activities as defined in subdivision (d) shall, prior to restructuring, secure approval from the director.

(b) Every nonprofit health care service plan that applies to the department to restructure its activities shall submit for approval by the department a public benefit program that identifies activities to be undertaken by the nonprofit health care service plan following restructuring to continue to meet its nonprofit public benefit obligations. The program shall include all information required pursuant to subdivisions (b) and (c) of Section 1399.70.

(c) The director shall apply the requirements of Section 1399.72 to the public benefit program submitted for approval as part of a restructuring proposal submitted pursuant to subdivision (b) of this section. The set-aside requirement in paragraph (1) of subdivision (c) of Section 1399.72 shall apply only to the fair value of the portion of the nonprofit health care service plan involved in the restructuring, as determined by the director.

(d) (1) For the purposes of this section, a ''restructuring'' or ''restructure'' by a nonprofit health care service plan means the sale, lease, conveyance, exchange, transfer, or other similar disposition of a substantial amount of a nonprofit health care service plan's assets, as determined by the director, to a business or entity carried on for profit. Nothing in this section shall be construed to prohibit the director from consolidating actions taken by a plan for the purpose of treating the consolidated actions as a restructuring or restructure of the plan.

(2) For the purposes of this section, a ''restructuring'' or ''restructure'' by a nonprofit health care service plan shall not include any sales or purchases undertaken in the normal and ordinary course

of plan business. The director may request information from the plan to verify that transactions qualify as occurring in the normal and ordinary course of plan business, and are not subject to the requirements of subdivision (e).

(e) Notwithstanding that a transaction or consolidated transactions involve a substantial amount of a nonprofit health care service plan's assets and are not in the normal and ordinary course of plan business, a ''restructuring'' or ''restructure'' by a nonprofit health care service plan shall not include any of the following transactions:

(1) Investments in a wholly owned subsidiary of the nonprofit health care service plan in which all of the following occur:

(A) Any profit from the investment will not inure to the benefit of any individual.

(B) The investment is fundamentally consistent with and advances the public benefit, charitable, or mutual benefit purpose of the plan.

(C) The investment does not adversely impact the plan's ability to fulfill its public benefit, charitable, or mutual benefit purposes.

(D) No officer or director of the plan has any financial interest constituting a conflict of interest in the investments.

(E) The investment results in the provision of services, goods, or insurance to or for the benefit of the plan or its members, enrollees, or groups.

(2) Sales or purchases of plan assets, including interests in wholly owned subsidiaries and in joint ventures, partnerships, and other investments in for-profit entities, in which all of the following occur:

(A) Any profit from the sale will not inure to the benefit of any individual.

(B) The sale or purchase is fundamentally consistent with and advances the public benefit, charitable, or mutual benefit purposes of the plan.

(C) The plan receives all proceeds from the sale.

(D) No officer or director of the plan has any financial interest constituting a conflict of interest in the sale or purchase.

(E) The transaction is conducted at arm's length and for fair market value.

(F) The sale or purchase does not adversely impact the plan's ability to fulfill its public benefit, charitable, or mutual benefit purposes.

(3) Investments in or joint ventures and partnerships with a for-profit entity in which all of the following occur:

(A) Any profit will not inure to the benefit of any individual.

(B) The mission or purpose of the investment, joint venture, or partnership is fundamentally consistent with the public benefit, charitable, or mutual benefit purposes of the plan.

(C) No officer or director of the plan has any financial interest constituting a conflict of interest in the investment, joint venture, or partnership.

(D) The transaction is conducted at arm's length and for fair market value.

(E) The investment, joint venture, or partnership furthers the plan's ability to fulfill its public benefit, charitable, or mutual benefit purposes.

(F) The investment, joint venture, or partnership results in the provision of services, goods, or insurance to or for the benefit of the plan or its members, enrollees, or groups.

The sharing of profits or earnings upon a reasonable and equitable basis reflecting the contribution of other participants to the investment, joint venture, or partnership or the success thereof shall not constitute private inurement.

(f) All transactions subject to the exemptions listed in subdivision (e) may not be executed by the plan without the written prior approval of the director. In the application for material modification seeking approval, the plan shall demonstrate that the proposed transaction meets all of the relevant conditions for exemption required by subdivision (e).

(g) Prior to issuing a decision to approve an application for a material modification involving a transaction that is exempt pursuant to subdivision (e), the director shall issue a public notice of the filing of the application and may seek public review and comment on the director's determination that the transaction is exempt under subdivision (e).

(h) The director may approve or deny the material modification request, or approve the request with conditions necessary to satisfy the requirements of this section, taking into consideration any public comments submitted to the director.

SEC. 160. Section 1399.72 of the Health and Safety Code is amended to read:

1399.72. (a) Any health care service plan that intends to convert from nonprofit to for-profit status, as defined in subdivision (b), shall, prior to the conversion, secure approval from the director.

(b) For the purposes of this section, a ''conversion'' or ''convert'' by a nonprofit health care service plan means the transformation of the plan from nonprofit to for-profit status, as determined by the director.

(c) Prior to approving a conversion, the director shall find that the conversion proposal meets all of the following charitable trust requirements:

(1) The fair market value of the nonprofit plan is set aside for appropriate charitable purposes. In determining fair market value, the director shall consider, but not be bound by, any market-based information available concerning the plan.

(2) The set-aside shall be dedicated and transferred to one or more existing or new tax-exempt charitable organizations operating pursuant to Section 501(c)(3) (26 U.S.C.A. Sec. 501(c)(3)) of the federal Internal Revenue Code. The director shall consider requiring that a portion of the set-aside include equity ownership in the plan. Further, the director may authorize the use of a federal Internal Revenue Code Section 501(c)(4) organization (26 U.S.C.A. Sec. 501(c)(4)) if, in the director's view, it is necessary to ensure effective management and monetization of equity ownership in the plan and if the plan agrees that the Section 501(c)(4) organization will be limited exclusively to these functions, that funds generated by the monetization shall be transferred to the Section 501(c)(3) organization except to the extent necessary to fund the level of activity of the Section 501(c)(4) organization as may be necessary to preserve the organization's tax status, that no funds or other resources controlled by the Section 501(c)(4) organization shall be expended for campaign contributions, lobbying, or other political activities, and that the Section 501(c)(4) organization shall comply with reporting requirements that are applicable to Section 501(c)(3) organizations, and that the 501(c)(4) organization shall be subject to any other requirements imposed upon 501(c)(3) organizations that the director determines to be appropriate.

(3) Each 501(c)(3) or 501(c)(4) organization receiving a set-aside, its directors and officers, and its assets including any plan stock, shall be independent of any influence or control by the health care service plan and its directors, officers, subsidiaries, or affiliates.

(4) The charitable mission and grant-making functions of the charitable organization receiving any set-aside shall be dedicated to serving the health care needs of the people of California.

(5) Every 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall have in place procedures and policies to prohibit conflicts of interest, including those associated with grant-making activities that may benefit the plan, including the directors, officers, subsidiaries, or affiliates of the plan.

(6) Every 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall demonstrate that its directors and officers have sufficient experience and judgment to administer grant-making and other charitable activities to serve the state's health care needs.

(7) Every 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall provide the director and the Attorney General with an annual report that includes a detailed description of its grant-making and other charitable activities related to its use of the set-aside received from the health care service plan. The annual report shall be made available by the director and the Attorney General for public inspection, notwithstanding the California Public Records Act (Chapter 3.5 (commencing with

Section 6250) of Division 7 of Title 1 of the Government Code). Each organization shall submit the annual report for its immediately preceding fiscal year within 120 days after the close of that fiscal year. When requested by the director or the Attorney General, the organization shall promptly supplement the report to include any additional information that the director or the Attorney General deems necessary to ascertain compliance with this article.

(8) The plan has satisfied the requirements of this chapter, and a disciplinary action pursuant to Section 1386 is not warranted against the plan.

(d) The plan shall not file any forms or documents required by the Secretary of State in connection with any conversion or restructuring until the plan has received an order of the director approving the conversion or restructuring, or unless authorized to do so by the director.

SEC. 161. Section 1399.73 of the Health and Safety Code is amended to read:

1399.73. (a) An application for a conversion or restructuring shall contain the information the director may require, by rule or order.

(b) The director shall charge a health care service plan an application filing fee. The fee for filing an application shall be the actual cost of processing the application, including the overhead costs. The filing fee shall include the costs of undertaking the activities described in subdivisions (c), (d), and (e) of Section 1399.74.

(c) The director may contract with experts or consultants to assist the director in reviewing the application. Contract costs shall not exceed an amount that is reasonable and necessary to review the application. Any contract entered into under this subdivision shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. The applicant shall promptly pay the director, upon request, for all contract costs.

SEC. 162. Section 1399.74 of the Health and Safety Code is amended to read:

1399.74. (a) By July 1, 1996, the director shall adopt regulations, on an emergency basis, that specify the application procedures and requirements for the restructuring or conversion of nonprofit health care service plans. This subdivision shall not be construed to limit or otherwise restrict the director's authority to adopt regulations under Section 1344, including, but not limited to, any additional regulations to implement this article.

(b) Upon receiving an application to restructure or convert, the director shall publish a notice in one or more newspapers of general circulation in the plan's service area describing the name of the applicant, the nature of the application, and the date of receipt of the

application. The notice shall indicate that the director will be soliciting public comments and will hold a public hearing on the application. The director shall require the plan to publish a written notice concerning the application pursuant to conditions imposed by rule or order.

(c) Any applications, reports, plans, or other documents under this article shall be public records, subject to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and regulations adopted by the director thereunder. The director shall provide the public with prompt and reasonable access to public records relating to the restructuring and conversion of health care service plans. Access to public records covered by this section shall be made available no later than one month prior to any solicitation for public comments or public hearing scheduled pursuant to this article.

(d) Prior to approving any conversion or restructuring, the director shall solicit public comments in written form and shall hold at least one public hearing concerning the plan's proposal to comply with the set- aside and other conditions required under this article.

(e) The director may disapprove any application to restructure or convert if the application does not meet the requirements of this chapter or of the Nonprofit Corporation Law (Div. 2 (commencing with Sec. 5000), Title 1, Corp. C.), including any requirements imposed by rule or order of the director.

SEC. 163. Section 1399.75 of the Health and Safety Code is amended to read:

1399.75. (a) This article shall apply to the restructuring or conversion of nonprofit mutual benefit health care service plans to the extent these plans have held or currently hold assets subject to a charitable trust obligation, as determined by the director.

(b) Nonprofit mutual benefit health care service plans that do not have, or have only a partial, charitable trust obligation, and that intend to convert or restructure their activities shall, prior to the conversion or restructuring, secure approval from the director.

(c) Prior to approving a mutual benefit health care service plan restructuring or conversion under subdivision (b), the director shall find that the plan has complied with its noncharitable obligations including, but not limited to, any obligations set forth in its articles of incorporation regarding the dedication and distribution of assets.

(d) The director, in carrying out the department's responsibilities under subdivision (c), may apply, to the extent appropriate in each case as determined by the director, the beneficiary protections authorized in this act, including, but not limited to, protections concerning the fair market value of assets, the avoidance of conflicts of interest, and the avoidance of undue influence or control, with respect to a mutual benefit plan's proposed disposition of assets.

(e) Nothing in this section shall be construed to limit the director's, Attorney General's, or a court's authority under existing law to impose charitable trust obligations upon any or all of the assets of a mutual benefit corporation or otherwise treat a mutual benefit corporation in the same manner as a public benefit corporation.

SEC. 164. Section 11758.47 of the Health and Safety Code is amended to read:

11758.47. Service providers may assist Medi-Cal beneficiaries, upon request, to file a fair hearing request in accordance with Chapter 7 (commencing with Section 10950) of Part 2 of Division 9 of the Welfare and Institutions Code, or may inform Medi-Cal beneficiaries about the Department of Managed Care's toll-free telephone number for health care service plan members or the State Department of Health Services' ombudsman for Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans.

SEC. 165. Section 32121 of the Health and Safety Code is amended to read:

32121. Each local district shall have and may exercise the following powers:

(a) To have and use a corporate seal and alter it at its pleasure.

(b) To sue and be sued in all courts and places and in all actions and proceedings whatever.

(c) To purchase, receive, have, take, hold, lease, use, and enjoy property of every kind and description within and without the limits of the district, and to control, dispose of, convey, and encumber the same and create a leasehold interest in the same for the benefit of the district.

(d) To exercise the right of eminent domain for the purpose of acquiring real or personal property of every kind necessary to the exercise of any of the powers of the district.

(e) To establish one or more trusts for the benefit of the district, to administer any trust declared or created for the benefit of the district, to designate one or more trustees for trusts created by the district, to receive by gift, devise, or bequest, and hold in trust or otherwise, property, including corporate securities of all kinds, situated in this state or elsewhere, and where not otherwise provided, dispose of the same for the benefit of the district.

(f) To employ legal counsel to advise the board of directors in all matters pertaining to the business of the district, to perform the functions in respect to the legal affairs of the district as the board may direct, and to call upon the district attorney of the county in which the greater part of the land in the district is situated for legal advice and assistance in all matters concerning the district, except that if that county has a county counsel, the directors may call upon the county counsel for legal advice and assistance.

(g) To employ any officers and employees, including architects and consultants, the board of directors deems necessary to carry on properly the business of the district.

(h) To prescribe the duties and powers of the health care facility administrator, secretary, and other officers and employees of any health care facilities of the district, to establish offices as may be appropriate and to appoint board members or employees to those offices, and to determine the number of, and appoint, all officers and employees and to fix their compensation. The officers and employees shall hold their offices or positions at the pleasure of the boards of directors.

(i) To do any and all things that an individual might do that are necessary for, and to the advantage of, a health care facility and a nurses' training school, or a child care facility for the benefit of employees of the health care facility or residents of the district.

(j) To establish, maintain, and operate, or provide assistance in the operation of, one or more health facilities or health services, including, but not limited to, outpatient programs, services, and facilities, retirement programs, services, and facilities, chemical dependency programs, services, and facilities, or other health care programs, services, and facilities and activities at any location within or without the district for the benefit of the district and the people served by the district.

''Health care facilities,'' as used in this subdivision, means those facilities defined in subdivision (b) of Section 32000.1 and specifically includes freestanding chemical dependency recovery units. ''Health facilities,'' as used in this subdivision, may also include those facilities defined in subdivision (d) of Section 15432 of the Government Code.

(k) To do any and all other acts and things necessary to carry out this division.

(*l*) To acquire, maintain, and operate ambulances or ambulance services within and without the district.

(m) To establish, maintain, and operate, or provide assistance in the operation of, free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and any other health care services provider, groups, and organizations that are necessary for the maintenance of good physical and mental health in the communities served by the district.

(n) To establish and operate in cooperation with its medical staff a coinsurance plan between the hospital district and the members of its attending medical staff.

(o) To establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the health care district.

(p) (1) To transfer, at fair market value, any part of its assets to one or more corporations to operate and maintain the assets. A

transfer pursuant to this paragraph shall be deemed to be at fair market value if an independent consultant, with expertise in methods of appraisal and valuation and in accordance with applicable governmental and industry standards for appraisal and valuation, determines that fair and reasonable consideration is to be received by the district for the transferred district assets. Before the district transfers, pursuant to this paragraph, 50 percent or more of the district's assets to one or more corporations, in sum or by increment, the elected board shall, by resolution, submit to the voters of the district a measure proposing the transfer. The measure shall be placed on the ballot of a special election held upon the request of the district or the ballot of the next regularly scheduled election occurring at least 88 days after the resolution of the board. If a majority of the voters voting on the measure vote in its favor, the transfer shall be approved. The campaign disclosure requirements applicable to local measures provided under Chapter 4 (commencing with Section 84100) of Title 9 of the Government Code shall apply to this election.

(2) To transfer, for the benefit of the communities served by the district, in the absence of adequate consideration, any part of the assets of the district, including without limitation real property, equipment, and other fixed assets, current assets, and cash, relating to the operation of the district's health care facilities to one or more nonprofit corporations to operate and maintain the assets.

(A) A transfer of 50 percent or more of the district's assets, in sum or by increment, pursuant to this paragraph shall be deemed to be for the benefit of the communities served by the district only if all of the following occur:

(i) The transfer agreement and all arrangements necessary thereto are fully discussed in advance of the district board decision to transfer the assets of the district in at least five properly noticed open and public meetings in compliance with the Ralph M. Brown Act, Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, and Section 32106.

(ii) The transfer agreement provides that the hospital district shall approve all initial board members of the nonprofit corporation and any subsequent board members as may be specified in the transfer agreement.

(iii) The transfer agreement provides that all assets transferred to the nonprofit corporation, and all assets accumulated by the corporation during the term of the transfer agreement arising out of or from the operation of the transferred assets, are to be transferred back to the district upon termination of the transfer agreement, including any extension of the transfer agreement.

(iv) The transfer agreement commits the nonprofit corporation to operate and maintain the district's health care facilities and its assets for the benefit of the communities served by the district.

(v) The transfer agreement requires that any funds received from the district at the outset of the agreement or any time thereafter during the term of the agreement be used only to reduce district indebtedness, to acquire needed equipment for the district health care facilities, to operate, maintain, and make needed capital improvements to the district's health care facilities, to provide supplemental health care services or facilities for the communities served by the district, or to conduct other activities that would further a valid public purpose if undertaken directly by the district.

(B) A transfer of 33 percent or more but less than 50 percent of the district's assets, in sum or by increment, pursuant to this paragraph shall be deemed to be for the benefit of the communities served by the district only if both of the following occur:

(i) The transfer agreement and all arrangements necessary thereto are fully discussed in advance of the district board decision to transfer the assets of the district in at least two properly noticed open and public meetings in compliance with the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), and Section 32106.

(ii) The transfer agreement meets all of the requirements of clauses (ii) to (v), inclusive, of subparagraph (A).

(C) A transfer of 10 percent or more but less than 33 percent of the district's assets, in sum or by increment, pursuant to this paragraph shall be deemed to be for the benefit of the communities served by the district only if both of the following occur:

(i) The transfer agreement and all arrangements necessary thereto are fully discussed in advance of the district board decision to transfer the assets of the district in at least two properly noticed open and public meetings in compliance with the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), and Section 32106.

(ii) The transfer agreement meets all of the requirements of clauses (iii) to (v), inclusive, of subparagraph (A).

(D) Before the district transfers, pursuant to this paragraph, 50 percent or more of the district's assets to one or more nonprofit corporations, in sum or by increment, the elected board shall, by resolution, submit to the voters of the district a measure proposing the transfer. The measure shall be placed on the ballot of a special election held upon the request of the district or the ballot of the next regularly scheduled election occurring at least 88 days after the resolution of the board. If a majority of the voters voting on the measure vote in its favor, the transfer shall be approved. The campaign disclosure requirements applicable to local measures provided under Chapter 4 (commencing with Section 84100) of Title 9 of the Government Code shall apply to this election.

(E) Notwithstanding the other provisions of this paragraph, a hospital district shall not transfer any portion of its assets to a private

nonprofit organization that is owned or controlled by a religious creed, church, or sectarian denomination in the absence of adequate consideration.

(3) If the district board has previously transferred less than 50 percent of the district's assets pursuant to this subdivision before any additional assets are transferred, the board shall hold a public hearing and shall make a public determination that the additional assets to be transferred will not, in combination with any assets previously transferred, equal 50 percent or more of the total assets of the district.

(4) The amendments to this subdivision made during the 1991–92 Regular Session, and the amendments made to this subdivision and to Section 32126 made during the 1993–94 Regular Session, shall only apply to transfers made on or after the effective dates of the acts amending this subdivision. The amendments to this subdivision made during those sessions shall not apply to any of the following:

(A) A district that has discussed and adopted a board resolution, prior to September 1, 1992, that authorizes the development of a business plan for an integrated delivery system.

(B) A lease agreement, transfer agreement, or both between a district and a nonprofit corporation that were in full force and effect as of September 1, 1992, for as long as that lease agreement, transfer agreement, or both remain in full force and effect.

(5) Notwithstanding paragraph (4), if substantial amendments are proposed to be made to a transfer agreement described in subparagraph (A) or (B) of paragraph (4), the amendments shall be fully discussed in advance of the district board's decision to adopt the amendments in at least two properly noticed open and public meetings in compliance with Section 32106 and the Ralph M. Brown Act, (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code).

(6) Notwithstanding paragraphs (4) and (5), a transfer agreement described in subparagraph (A) or (B) of paragraph (4) that provided for the transfer of less than 50 percent of a district's assets shall be subject to the requirements of subdivision (p) of Section 32121 when subsequent amendments to that transfer agreement would result in the transfer, in sum or by increment, of 50 percent or more of a district's assets to the nonprofit corporation.

(7) For purposes of this subdivision, a ''transfer'' means the transfer of ownership of the assets of a district. A lease of the real property or the tangible personal property of a district shall not be subject to this subdivision except as specified in Section 32121.4 and as required under Section 32126.

(8) Districts that request a special election pursuant to paragraph (1) or (2) shall reimburse counties for the costs of that special election as prescribed pursuant to Section 10520 of the Elections Code.

(9) Nothing in this section, including subdivision (j), shall be construed to permit a local district to obtain or be issued a single consolidated license to operate a separate physical plant as a skilled nursing facility or an intermediate care facility that is not located within the boundaries of the district.

(10) A transfer of any of the assets of a district to one or more nonprofit corporations to operate and maintain the assets shall not be required to meet paragraphs (1) to (9), inclusive, of this subdivision if all of the following conditions apply at the time of the transfer:

(A) The district has entered into a loan that is insured by the State of California under Chapter 1 (commencing with Section 129000) of Part 6 of Division 107.

(B) The district is in default of its loan obligations, as determined by the Office of Statewide Health Planning and Development.

(C) The Office of Statewide Health Planning and Development and the district, in their best judgment, agree the transfer of some or all of the assets of the district to a nonprofit corporation or corporations is necessary to cure the default, and will obviate the need for foreclosure. This cure of default provision shall be applicable prior to the office foreclosing on district hospital assets. After the office has foreclosed on district hospital assets, or otherwise taken possession in accordance with law, the office may exercise all of its powers to deal with and dispose of hospital property.

(D) The transfer and all arrangements necessary thereto are discussed in advance of the transfer in at least one properly noticed open and public meeting in compliance with the Ralph M. Brown Act, Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code and Section 32106. The meeting referred to in this paragraph shall be noticed and held within 90 days of notice in writing to the district by the office of an event of default. If the meeting is not held within this 90-day period, the district shall be deemed to have waived this requirement to have a meeting.

(11) If a transfer under paragraph (10) is a lease, the lease shall provide that the assets shall revert to the district at the conclusion of the leasehold interest. If the transfer is a sale, the proceeds shall be used first to retire the obligation insured by the office, then to retire any other debts of the district. After providing for debts, any remaining funds shall revert to the district.

(q) To contract for bond insurance, letters of credit, remarketing services, and other forms of credit enhancement and liquidity support for its bonds, notes, and other indebtedness and to enter into reimbursement agreements, monitoring agreements, remarketing agreements, and similar ancillary contracts in connection therewith.

(r) To establish, maintain, operate, participate in, or manage capitated health care plans, health maintenance organizations, preferred provider organizations, and other managed health care systems and programs properly licensed by the Department of

Insurance or the Department of Managed Care, at any location within or without the district for the benefit of residents of communities served by the district. However, that activity shall not be deemed to result in or constitute the giving or lending of the district's credit, assets, surpluses, cash, or tangible goods to, or in aid of, any person, association, or corporation in violation of Section 6 of Article XVI of the California Constitution.

Nothing in this section shall authorize activities that corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the Business and Professions Code.

Any agreement to provide health care coverage that is a health care service plan, as defined in subdivision (f) of Section 1345, shall be subject to the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2, unless exempted pursuant to Section 1343 or 1349.2.

A district shall not provide health care coverage for any employee of an employer operating within the communities served by the district, unless the Legislature specifically authorizes, or has authorized in this section or elsewhere, the coverage.

This section shall not authorize any district to contribute its facilities to any joint venture that could result in transfer of the facilities from district ownership.

(s) To provide health care coverage to members of the district's medical staff, employees of the medical staff members, and the dependents of both groups, on a self-pay basis.

(t) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2001, deletes or extends that date.

SEC. 166. Section 34943 of the Health and Safety Code is amended to read:

34943. The provisions of the Corporate Securities Law of 1968 not inconsistent with this chapter apply to a corporation formed under this chapter.

SEC. 167. Section 102910 of the Health and Safety Code is amended to read:

102910. For the purpose of conducting the three-year study required pursuant to Section 102905, the department is hereby encouraged to contract with a federally recognized tribe or tribal organization or an American Indian-controlled health care corporation or research institution having a record of good standing with the Department of Managed Care and the Indian Health program within the department, and established competence in the area of records management.

SEC. 168. Section 127580 of the Health and Safety Code is amended to read:

127580. The office, after consultation with the Insurance Commissioner, the Director of the Department of Managed Care,

the State Director of Health Services, and the Director of Industrial Relations, shall adopt a California uniform billing form format for professional health care services and a California uniform billing form format for institutional provider services. The format for professional health care services shall be the format developed by the National Uniform Claim Form Task Force. The format for institutional provider services shall be the format developed by the National Uniform Billing Committee. The formats shall be acceptable for billing in federal Medicare and medicaid programs. The office shall specify a single uniform system for coding diagnoses, treatments, and procedures to be used as part of the uniform billing form formats. The system shall be acceptable for billing in federal Medicare and medicaid programs.

SEC. 169. Section 128725 of the Health and Safety Code is amended to read:

128725. The functions and duties of the commission shall include the following:

(a) Advise the office on the implementation of the new, consolidated data system.

(b) Advise the office regarding the ongoing need to collect and report health facility data and other provider data.

(c) Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.

(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.

(e) Conduct public meetings for the purposes of obtaining input from health facilities, other providers, data users, and the general public regarding this chapter and Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.

(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.

(h) Advise the office on the format of individual health facility or other provider data reports and on any technical and procedural issues necessary to implement this part.

(i) Advise the office on the formulation of general policies which shall advance the purposes of Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(j) Recommend, in consultation with a 12-member technical advisory committee appointed by the chairperson of the commission, to the office the data elements necessary for the production of outcome reports required by Section 128745.

(k) (1) The technical advisory committee appointed pursuant to subdivision (j) shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by the California Association of Hospitals and Health Systems, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical Association, two members who shall be registered nurses appointed from a list of at least six persons nominated by the California Nurses Association, one medical record practitioner who shall be appointed from a list of at least six persons nominated by the California Health Information Association, one member who shall be a representative of a hospital authorized to report as a group pursuant to subdivision (d) of Section 128760, two members who shall be representative of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, and one member representing the Consumers Union. Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee.

(2) The commission shall submit its recommendation to the office regarding the first of the reports required pursuant to subdivision (a) of Section 128745 no later than January 1, 1993. The technical advisory committee shall submit its initial recommendations to the commission pursuant to subdivision (d) of Section 128750 no later than January 1, 1994. The commission, with the advice of the technical advisory committee, may periodically make additional recommendations under Sections 128745 and 128750 to the office, as appropriate.

(*l*) (1) Assess the value and usefulness of the reports required by Sections 127285, 128735, and 128740. On or before December 1, 1997, the commission shall submit recommendations to the office to accomplish all of the following:

(A) Eliminate redundant reporting.

(B) Eliminate collection of unnecessary data.

(C) Augment data bases as deemed valuable to enhance the quality and usefulness of data.

(D) Standardize data elements and definitions with other health data collection programs at both the state and national levels.

(E) Enable linkage with, and utilization of, existing data sets.

(F) Improve the methodology and data bases used for quality assessment analyses, including, but not limited to, risk-adjusted outcome reports.

(G) Improve the timeliness of reporting and public disclosure.

(2) The commission shall establish a committee to implement the evaluation process. The committee shall include representatives

from the health care industry, providers, consumers, payers, purchasers, and government entities, including the Department of Managed Care, the departments that comprise the Health and Welfare Agency, and others deemed by the commission to be appropriate to the evaluation of the data bases. The committee may establish subcommittees including technical experts.

(3) In order to ensure the timely implementation of the provisions of the legislation enacted in the 1997–98 Regular Session that amended this part, the office shall present an implementation work plan to the commission. The work plan shall clearly define goals and significant steps within specified timeframes that must be completed in order to accomplish the purposes of that legislation. The office shall make periodic progress reports based on the work plan to the commission. The commission may advise the Secretary of Health and Welfare of any significant delays in following the work plan. If the commission determines that the office is not making significant progress toward achieving the goals outlined in the work plan, the commission shall notify the office and the secretary of that determination. The commission may request the office to submit a plan of correction outlining specific remedial actions and timeframes for compliance. Within 90 days of notification, the office shall submit a plan of correction to the commission.

(m) (1) As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.

(2) Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.

(3) The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.

SEC. 170. Section 740 of the Insurance Code is amended to read:

740. (a) Notwithstanding any other provision of law, and except as provided herein, any person or other entity that provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be

subject to the jurisdiction of the department unless the person or other entity shows that while providing the services it is subject to the jurisdiction of another agency of this or another state or the federal government.

(b) A person or entity may show that it is subject to the jurisdiction of another agency of this or another state or the federal government by providing to the commissioner the appropriate certificate or license issued by the other governmental agency that permits or qualifies it to provide those services for which it is licensed or certificated.

(c) Any person or entity that is unable to show that it is subject to the jurisdiction of another agency of this or another state or the federal government, shall submit to an examination by the commissioner to determine the organization and solvency of the person or the entity, and to determine whether the person or entity is in compliance with the applicable provisions of this code, and shall be required to obtain a certificate of authority to do business in California and be required to meet all appropriate reserve, surplus, capital, and other necessary requirements imposed by this code for all insurers.

(d) Any person or entity unable to show that it is subject to the jurisdiction of another agency of this or another state or the federal government shall be subject to all appropriate provisions of this code regarding the conduct of its business.

(e) The department shall prepare and maintain for public inspection a list of those persons or entities described in subdivision (a) that are not subject to the jurisdiction of another agency of this or another state or the federal government and that the department knows to be operating in this state. There shall be no liability of any kind on the part of the state, the department, and its employees for the accuracy of the list or for any comments made with respect to it.

(f) Any administrator licensed by the department who advertises or administers coverage in this state described in subdivision (a), that is provided by any person or entity described in subdivision (c), and where the coverage does not meet all pertinent requirements specified in this code and that is not provided or completely underwritten, insured or otherwise fully covered by an admitted life or disability insurer, hospital service plan or health care service plan, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, and any production agency licensed by the department involved in the transaction, all financial and operational information relative to the content and scope of the plan and, specifically, as to the lack of insurance or other coverage.

Any production agency obtaining knowledge of any coverage relative to the content and scope of a hospital service plan or health care service plan, as required under this subdivision, shall advise and disclose to any purchaser, prospective purchaser, covered person or

entity, the knowledge regarding the content and scope of the plan and, specifically, as to the lack of insurance by an admitted carrier or other qualified plan.

(g) A health care service plan, as defined in Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, shall not be subject to this section.

(h) The department shall notify, in writing, the Director of the Department of Managed Care whenever it determines that a multiple employer trust qualifies as a health care service plan subject to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(i) Any health care service plan, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, or political subdivision, or a public joint labor management trust as described in subdivision (c) of Section 1349.2 of the Health and Safety Code, that is exempt pursuant to Section 1349.2 of the Health and Safety Code from the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), is also exempt from this code.

SEC. 171. Section 742.407 of the Insurance Code is amended to read:

742.407. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by a multiple employer welfare arrangement.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in

economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's ''written authorization,'' as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

SEC. 172. Section 791.02 of the Insurance Code is amended to read:

791.02. As used in this act:

(a) (1) ''Adverse underwriting decision'' means any of the following actions with respect to insurance transactions involving insurance coverage which is individually underwritten:

(A) A declination of insurance coverage.

(B) A termination of insurance coverage.

(C) Failure of an agent to apply for insurance coverage with a specific insurance institution which the agent represents and which is requested by an applicant.

(D) In the case of a property or casualty insurance coverage:

(i) Placement by an insurance institution or agent of a risk with a residual market mechanism, with an unauthorized insurer, or with an insurance institution which provides insurance to other than preferred or standard risks, if in fact the placement is at other than a preferred or standard rate. An adverse underwriting decision, in case of placement with an insurance institution which provides insurance to other than preferred or standard risks, shall not include such placement where the applicant or insured did not specify or apply for placement as a preferred or standard risk or placement with a particular company insuring preferred or standard risks, or

(ii) The charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished.

(E) In the case of a life, health or disability insurance coverage, an offer to insure at higher than standard rates.

(2) Notwithstanding paragraph (1), any of the following actions shall not be considered adverse underwriting decisions but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

(A) The termination of an individual policy form on a class or statewide basis.

(B) A declination of insurance coverage solely because such coverage is not available on a class or statewide basis.

(C) The rescission of a policy.

(b) ''Affiliate'' or ''affiliated'' means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

(c) ''Agent'' means any person licensed pursuant to Chapter 5 (commencing with Section 1621), Chapter 5A (commencing with Section 1759), Chapter 6 (commencing with Section 1760), Chapter 7 (commencing with Section 1800), or Chapter 8 (commencing with Section 1831).

(d) ''Applicant'' means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

(e) ''Consumer report'' means any written, oral or other communication of information bearing on a natural person's creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which is used or expected to be used in connection with an insurance transaction.

(f) ''Consumer reporting agency'' means any person who:

(1) Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee.

(2) Obtains information primarily from sources other than insurance institutions.

(3) Furnishes consumer reports to other persons.

(g) ''Control,'' including the terms ''controlled by'' or ''under common control with,'' means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(h) ''Declination of insurance coverage'' means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

(i) ''Individual'' means any natural person who:

(1) In the case of property or casualty insurance, is a past, present or proposed named insured or certificate holder;

(2) In the case of life or disability insurance, is a past, present or proposed principal insured or certificate holder;

(3) Is a past, present or proposed policyowner;

(4) Is a past or present applicant; or

(5) Is a past or present claimant; or

(6) Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate subject to this act.

(j) ''Institutional source'' means any person or governmental entity that provides information about an individual to an agent, insurance institution or insurance-support organization, other than:

(1) An agent,

(2) The individual who is the subject of the information, or

(3) A natural person acting in a personal capacity rather than in a business or professional capacity.

(k) ''Insurance institution'' means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance, including medical service plans and hospital service plans. ''Insurance institution'' shall not include agents, insurance-support organizations, or group practice prepayment health care service plans regulated pursuant to the Knox-Keene Health Care Service Plan Act, Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(*l*) ''Insurance-support organization'' means:

(1) Any person who regularly engages, in whole or in part, in the business of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including:

(A) The furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction, or

(B) The collection of personal information from insurance institutions, agents or other insurance-support organizations for the purpose of detecting or preventing fraud, material

misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(2) Notwithstanding paragraph (1), the following persons shall not be considered ''insurance-support organizations'': agents, governmental institutions, insurance institutions, medical care institutions, medical professionals, and peer review committees.

(m) ''Insurance transaction'' means any transaction involving insurance primarily for personal, family or household needs rather than business or professional needs which entails:

(1) The determination of an individual's eligibility for an insurance coverage, benefit or payment, or

(2) The servicing of an insurance application, policy, contract or certificate.

(n) ''Investigative consumer report'' means a consumer report or portion thereof in which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning such items of information.

(o) ''Medical care institution'' means any facility or institution that is licensed to provide health care services to natural persons, including but not limited to, hospitals, skilled nursing facilities, home health agencies, medical clinics, rehabilitation agencies and public health agencies.

(p) ''Medical professional'' means any person licensed or certified to provide health care services to natural persons, including but not limited to, a physician, dentist, nurse, optometrist, physical or occupational therapist, psychiatric social worker, clinical dietitian, clinical psychologist, chiropractor, pharmacist, or speech therapist.

(q) ''Medical record information'' means personal information which:

(1) Relates to an individual's physical or mental condition, medical history or medical treatment, and

(2) Is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent or legal guardian.

(r) ''Person'' means any natural person, corporation, association, partnership, limited liability company, or other legal entity.

(s) ''Personal information'' means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics. ''Personal information'' includes an individual's name and address and ''medical record information'' but does not include ''privileged information.''

(t) ''Policyholder'' means any person who:

(1) In the case of individual property or casualty insurance, is a present named insured;

(2) In the case of individual life or disability insurance, is a present policyowner; or

(3) In the case of group insurance which is individually underwritten, is a present group certificate holder.

(u) ''Pretext interview'' means an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

(1) Pretends to be someone he or she is not,

(2) Pretends to represent a person he or she is not in fact representing,

(3) Misrepresents the true purpose of the interview, or

(4) Refuses to identify himself or herself upon request.

(v) ''Privileged information'' means any individually identifiable information that both:

(1) Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual.

(2) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual. However, information otherwise meeting the requirements of this division shall nevertheless be considered ''personal information'' under this act if it is disclosed in violation of Section 791.13.

(w) ''Residual market mechanism'' means the California FAIR Plan Association, Chapter 10 (commencing with Section 10101) of Part 1 of Division 2, and the assigned risk plan, Chapter 1 (commencing with Section 11550) of Part 3 of Division 2.

(x) ''Termination of insurance coverage'' or ''termination of an insurance policy'' means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

(y) ''Unauthorized insurer'' means an insurance institution that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state.

(z) ''Commissioner'' means the Insurance Commissioner; except in the case of a person or entity subject to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and except as to any person defined in subdivision (k) when engaged in providing information or evaluation to a person or entity subject to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, and in such instances only, the term ''commissioner'' shall mean the Director of the Department of Managed Care.

(aa) ''Insurance'' includes a medical service or hospital service agreement or contract issued by a person or entity subject to the

Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

SEC. 173. Section 1068 of the Insurance Code is amended to read:

1068. (a) As used in this section, the following definitions shall apply:

(1) ''Health care service plan'' means any plan as defined in Section 1345 of the Health and Safety Code, but this section does not apply to specialized health care service contracts.

(2) ''Carrier'' means a health care service plan, an insurer issuing group disability coverage which covers hospital, medical, or surgical expenses, a nonprofit hospital service plan, or any other entity responsible for either the payment of benefits for or the provision of hospital, medical, and surgical benefits under a group contract.

(3) ''Insolvency'' means that the Director of the Department of Managed Care has determined that the health care service plan is not financially able to provide health care services to its enrollees and (A) the Director of the Department of Managed Care has taken an action pursuant to Section 1386, 1391, or 1399 of the Health and Safety Code, or (B) an order requested by the Director of the Department of Managed Care or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1 of the Health and Safety Code.

(b) In the event of the insolvency of a health care service plan, upon order of the commissioner which shall be issued following his or her receipt of a notice issued by the Director of the Department of Managed Care pursuant to Section 1394.7 of the Health and Safety Code, any insurer, nonprofit hospital service plan, and any other entity, other than a health care service plan, responsible for either the payment of benefits for or the provision of hospital, medical, and surgical benefits under a group contract, that participated in the enrollment process with the insolvent health care service plan at the last regular open enrollment period of a group, shall offer enrollees of the group in the insolvent health care service plan a 30-day enrollment period commencing upon the date of insolvency. Each such carrier shall offer enrollees of the group in the insolvent health care service plan the same coverages and rates that it offered to enrollees of the group at the last regular open enrollment period of the group.

SEC. 174. Section 1068.1 of the Insurance Code is amended to read:

1068.1. (a) As used in this section:

(1) ''Carrier'' means a specialized health care service plan, and any of the following entities which offer coverage comparable to the coverages offered by a specialized health care service plan: an insurer issuing group disability coverage; a nonprofit hospital service plan; or

other entity responsible for either the payment of benefits for or the provision of services under a group contract.

(2) ''Insolvency'' means that the Director of the Department of Managed Care has determined that the specialized health care service plan is not financially able to provide specialized health care services to its enrollees and (A) the Director of the Department of Managed Care has taken an action pursuant to Section 1386, 1391, or 1399 of the Health and Safety Code, or (B) an order requested by the commissioner or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1 of the Health and Safety Code.

(3) ''Specialized health care service plan'' means any plan authorized to issue only specialized health care service plan contracts as defined in Section 1345 of the Health and Safety Code.

(b) In the event of the insolvency of a specialized health care service plan, upon order of the commissioner which shall be issued following his or her receipt of a notice issued by the Director of the Department of Managed Care pursuant to Section 1394.8 of the Health and Safety Code, all carriers that participated in the enrollment process with the insolvent specialized health care service plan at a group's last regular open enrollment period for the same type of specialized health care service benefits shall offer the group's enrollees in the insolvent specialized health care service plan a 30-day enrollment period commencing upon the date of insolvency. Each such carrier shall offer enrollees of the insolvent specialized health care service plan the same specialized coverage and rates that it had offered to the enrollees of the group at its last regular open enrollment period.

SEC. 175. Section 10123.35 of the Insurance Code is amended to read:

10123.35. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by a self-insured welfare benefit plan.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five

thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's ''written authorization,'' as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

SEC. 176. Section 10140.1 of the Insurance Code is amended to read:

10140.1. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by

an admitted insurer licensed to issue life or disability insurance, except life and disability income policies issued or delivered on or after January 1, 1995, that are contingent upon review or testing for other diseases or medical conditions.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics, of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's ''written authorization,'' as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

SEC. 178. Section 10196 of the Insurance Code is amended to read:

10196. (a) The commissioner, with the advice of the Department of Managed Care, shall prepare a guide that explains the factors to be considered in selecting long-term care insurance and the consequences of particular clauses and exclusions. The guide shall be made available to the public and to interested organizations upon request. Any advertisement in this state dealing with long-term care insurance shall include notice of availability of this guide from the commissioner.

(b) For purposes of this section, ''long-term care insurance'' means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. ''Long-term care insurance'' does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, or specified disease or accident coverage.

SEC. 179. Section 10270.98 of the Insurance Code is amended to read:

10270.98. Group disability policies may provide, among other things, that the benefits payable thereunder are subject to reduction if the individual insured has any other coverage (other than individual policies or contracts) providing hospital, surgical or medical benefits, whether on an indemnity basis or a provision of service basis, resulting in such insured being eligible for more than 100 percent of the covered expenses.

Except as permitted by this section and by Section 10323, 10369.5, 10369.6, or 11515.5, and except in the case of group practice prepayment plan contracts which do not provide for coordination of benefits, to the extent they provide for a reduction of benefits on account of other coverage with respect to emergency services that are not obtained from providers that contract with the plan, no group or individual disability insurance policy or service contract issued by nonprofit hospital service plans operating under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 shall limit payment of benefits by reason of the existence of other insurance or service coverage.

The policy provisions authorized by this section shall contain a provision that payments of funds may be made directly between insurers and other providers of benefits. Such policy provisions shall also contain a provision that if benefits are provided in the form of services rather than cash payments the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. The reasonable cash value of any contractual benefit provided to the insured in the form of service rather than cash payment by or through any hospital service organization or medical service organization or group-practice prepayment plan shall be deemed an expense incurred by the insured for such service, whether or not actually incurred, and the liability of the insurer shall be the same as if the insured had not been entitled to any such service benefit, unless the policy contains a provision authorized by Section 10323, 10369.5 or 10369.6 in the case of an individual disability policy, or by this section, in the case of a group disability policy.

This section shall not be construed to require that benefits payable under group disability policies be subject to reduction by the benefit amounts payable under Chapter 3 (commencing with Section 2800) of Part 2 of Division 1 of the Unemployment Insurance Code.

The provisions of this section, and all regulations adopted pursuant thereto pertaining to coordination of benefits with other group disability benefits, shall apply to all employers, labor-management trustee plans, union welfare plans (including those established in conformity with 29 U.S.C. Sec. 186), employer organization plans or employee benefit organization plans, health care service plan contracts, pursuant to regulations adopted by the Director of the Department of Managed Care which shall be uniform with those issued under this section for those plans that elect to coordinate benefits, group practice, individual practice, any other prepayment coverage for medical or dental care or treatment, and administrators, within the meaning of Section 1759 not otherwise subject to the provisions of this section whenever such plan, contract or practice provides or administers hospital, surgical, medical or dental benefits to employees or agents who are also covered under one or more

additional group disability policies which are subject to this section or health care service plans.

SEC. 180. Section 10704 of the Insurance Code is amended to read:

10704. The commissioner may issue regulations that are necessary to carry out the purposes of this chapter. Prior to the public comment period required on the regulations under the Administrative Procedure Act, the commissioner shall provide the Director of the Department of Managed Care with a copy of the proposed regulations. The Director of the Department of Managed Care shall have 30 days to notify the commissioner in writing of any comments on the regulations. The Director of the Department of Managed Care's comments shall be included in the public notice issued on the regulations. Any rules and regulations issued pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until December 31, 1994, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The regulations shall be enforced by the director.

SEC. 181. Section 10733 of the Insurance Code is amended to read:

10733. On or after the effective date of this chapter, the board shall enter into contracts with carriers for the purpose of providing health benefits coverage to eligible employees and dependents. Participating carriers shall have, but need not be limited to, all of the following operating characteristics satisfactory to the board:

(a) Strong financial condition, including the ability to assume the risk of providing and paying for covered services. A participating carrier may utilize reinsurance, provider risk sharing, and other appropriate mechanisms to share a portion of the risk.

(b) Adequate administrative management.

(c) In the case of the health care service plan, the following requirements must be met: (1) on the effective date of the contract, the health care service plan must be in compliance with the minimum tangible net equity requirements of the Director of the Department of Managed Care as those requirements will be in effect on January 1, 1995, and must remain in compliance with these requirements throughout the duration of the contract; (2) (A) before the effective date of the contract, the health care service plan must have devised a system for identifying in a simple and clear fashion both in its own records and in the medical records of subscribers and enrollees the fact that the services provided are provided under the program; and (B) throughout the duration of the contract, the health care service plan must use that system; and (3) at least 30 days before the effective date of any contract with the

board, the health care service plan must inform the Director of the Department of Managed Care in writing of the health care service plan's intent to enter into the contract and must demonstrate in that letter, to the satisfaction of the Director of the Department of Managed Care, that it has complied with the requirements of paragraphs (1) and (2).

(d) A satisfactory grievance procedure.

(e) Participating carriers that contract with or employ health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the board, in consultation with the carrier's licensing agency.

(1) Review the quality of care covered.

(2) Review the appropriateness of care covered.

(3) Provide accessible health care services.

SEC. 182. Section 10734 of the Insurance Code is amended to read:

10734. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Care, as the case may be.

(b) Participating carriers that contract with the program shall be licensed and in good standing with their licensing agencies.

SEC. 183. Section 10810 of the Insurance Code is amended to read:

10810. As used in this chapter:

(a) ''Ancillary benefit plan'' means a policy or contract written or administered by a participating carrier that covers dental or vision benefits for the covered eligible employees of an employer or small employer and their dependents.

(b) ''Appropriate Regulatory Authority'' means the Department of Insurance except for health care service plans, in which case it means the Department of Managed Care.

(c) ''Benefit plan design'' means a specific health coverage product issued by a carrier to employers or small employers, to trustees of associations, or to individuals if the coverage is offered through employment or sponsored by an employer or small employer. It includes the services covered and the levels of copayment and deductibles.

(d) ''Board'' means the governing body of the purchasing alliance. This term shall include the board of directors of a nonprofit corporation or trust, a for-profit corporation, the general partners of a partnership, or a sole proprietor.

(e) ''Carrier'' means any licensed disability insurance company or licensed health care service plan or any other entity that writes, issues, or administers any health benefit plan or ancillary benefit plan to employers or small employers in this state.

(f) ''Commissioner'' means the Insurance Commissioner, who shall have regulatory jurisdiction over purchasing alliances.

(g) ‘‘Dependent’’ has the same meaning as in the subdivision (a) of Section 1357 of the Health and Safety Code and in subdivision (e) of Section 10700 of this code.

(h) ‘‘Eligible employee’’ means any permanent employee who is actively engaged on a full-time basis in the conduct of business of the employer or small employer and, who has satisfied any employer or small employer waiting period requirements. The term includes sole proprietors or partners of a partnership if they are actively engaged on a full-time basis in the employer’s or small employer’s business, but does not include employees who work on a part-time, temporary, or substitute basis.

(i) ‘‘Employer’’ means any corporation, partnership, sole proprietorship, or other business entity doing business in this state that may be eligible to participate in a purchasing alliance. The term ‘‘employer’’ shall not include ‘‘small employer’’ as defined in subdivision (s).

(j) ‘‘Enrollee’’ means an eligible employee or a dependent of an eligible employee who is enrolled in a health benefit plan or ancillary benefit plan offered through the purchasing alliance by a participating carrier.

(k) ‘‘Health benefit plan’’ means a policy or contract written or administered by a participating carrier that arranges or provides health care benefits for the covered eligible employees of an employer or small employer and their dependents. The term does not include accident only, credit, dental, vision, disability income, or long-term care insurance, coverage issued as a supplement to liability insurance, automobile medical payments insurance, or insurance under which benefits are payable with or without regard to fault and is statutorily required to be continued in any liability insurance policy or equivalent self-insurance.

(*l*) ‘‘Management company’’ means the company under contract to the purchasing alliance to provide managerial services for the operation of the purchasing alliance.

(m) ‘‘Participating carrier’’ means a carrier that contracts with a purchasing alliance to provide coverage to enrollees under a health benefit plan or ancillary benefit plan.

(n) ‘‘Participating employer’’ means an employer or small employer who contracts with a purchasing alliance to provide coverage to the employer’s or small employer’s employees.

(o) ‘‘Purchasing alliance’’ means a non-risk-bearing entity issued a certificate of registration pursuant to this chapter to provide health benefits through multiple unaffiliated participating carriers to multiple participating employers, small employers and their employees within this state as authorized by the commissioner. That entity shall include nonprofit corporations, for-profit corporations, trusts, partnerships, and sole proprietorships.

(p) ‘‘Risk adjustment factor’’ for small employer benefit plan designs and contracts has the same meaning as in subdivision (j) of Section 1357 of the Health and Safety Code and in subdivision (u) of Section 10700 of this code.

(q) ‘‘Service region’’ means that portion of the state, designated by the commissioner pursuant to regulations as described in this chapter in which each purchasing alliance must fairly and affirmatively offer, market, and sell all of the health benefit plan designs offered through the purchasing alliance that are sold or offered to a small employer to all small employers.

(r) ‘‘Small employer’’ has the same meaning as in paragraph (1) of subdivision (*l*) of Section 1357 of the Health and Safety Code and in paragraph (1) of subdivision (w) of Section 10700 of this code.

(s) ‘‘Third-party administrator’’ means the company contracted by the purchasing alliance to provide administrative services for the purchasing alliance and that is licensed to provide those services by the department pursuant to Section 1759.10.

SEC. 184. Section 10820 of the Insurance Code is amended to read:

10820. (a) The commissioner shall regulate the establishment and conduct of purchasing alliances as set forth in this chapter.

(b) No person or entity may market, sell, offer, or contract for a package of one or more health benefit plans underwritten by two or more carriers to two or more employers or small employers or their eligible employees within a purchasing alliance without first being registered by the commissioner pursuant to this chapter. This subdivision does not apply to entities licensed by the Department of Managed Care as health care service plans or entities licensed by the Department of Insurance as disability insurers except that no licensed health care service plan or licensed disability insurer may be registered with the commissioner as a purchasing alliance. This chapter does not apply to any entity exempt pursuant to Section 1349.2 of the Health and Safety Code.

(c) A person or entity not registered by the commissioner as a purchasing alliance and engaged in the purchase, sale, marketing or distribution of health insurance or health care benefit plans shall not hold itself out as an alliance, health insurance purchasing alliance, purchasing alliance, health alliance, health insurance purchasing cooperative, or purchasing cooperative, or otherwise use a confusingly similar name.

(d) The commissioner shall establish six geographic service regions throughout which all purchasing alliances shall operate. These regions shall be established with no region smaller than an area in which the first three digits of all its postal ZIP Codes are in common within a county and shall divide no county into more than two service regions. Geographic service regions established pursuant to this section shall, as a group, cover the entire state, and the areas

encompassed in geographic service regions shall be separate and distinct from regions encompassed in other geographic service regions. Geographic service regions may be noncontiguous.

(e) Nothing in this chapter shall be deemed to be in conflict with or limit the duties and powers granted to the commissioner under the laws of this state.

(f) Purchasing alliances shall report to the commissioner any suspected or alleged law violations of this chapter.

(g) Violations of this chapter shall be subject to the penalties outlined hereafter.

(h) The commissioner shall adopt reasonable rules and regulations as are necessary to administer this chapter.

(i) Nothing in this chapter shall be construed or interpreted to apply to an entity that has been approved by the Director of the Department of Managed Care, pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to act as a solicitor and third-party administrator with respect to a multiple carrier or health care service plan marketing cooperative in which each carrier or health care service plan contracts directly with subscribing groups or individuals for the provision of health care, for the arranging for the provision of health care, or for the provision of coverage for health care.

SEC. 185. Section 10856 of the Insurance Code is amended to read:

10856. Nothing in this article shall be construed to limit the existing regulatory authority of the Department of Managed Care to regulate health care service plans or of the Department of Insurance to regulate disability or life insurers or hospital service plans. None of the requirements of this article shall conflict with the participating carrier's licensing requirements.

SEC. 186. Section 12693.36 of the Insurance Code is amended to read:

12693.36. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Care, as the case may be.

(b) Participating health, dental, and vision plans that contract with the program and are regulated by either the Insurance Commissioner or the Department of Managed Care shall be licensed and in good standing with their respective licensing agencies. In their application to the program, those entities shall provide assurance of their standing with the appropriate licensing entity.

(c) Local initiatives that have a contract with the State Department of Health Services, and that contract with the program, and that are licensed by the Department of Managed Care but do not have a commercial license from the Department of Managed Care, may contract with the board for a maximum of 18 months. During this

18-month period, those plans shall be in good standing with the Department of Managed Care and shall demonstrate to the board that they are making a good faith effort to obtain a commercial license with the Department of Managed Care. The board may extend this period to 24 months if the board determines the additional time is necessary to comply with this requirement. In their application to the program, those entities shall provide assurance of their standing with the Department of Managed Care and shall outline their plans for obtaining commercial licensure.

(d) County organized health systems and the special health care authority established under Section 101675 of the Health and Safety Code that have a contract with the State Department of Health Services, and that contract with the program, and that are not licensed by either the Insurance Commissioner or the Department of Managed Care may contract with the board for a maximum of 24 months. During this 24-month period those plans shall be in good standing with the state agency providing oversight to their operations and shall demonstrate to the board that they are making a good faith effort to obtain licensure with the Department of Insurance or the Department of Managed Care. In their application to the program, those entities shall provide assurance of their standing with the appropriate state oversight entity and shall outline their plans for obtaining licensure from the Department of Insurance or the Department of Managed Care.

SEC. 187. Section 12693.365 of the Insurance Code is amended to read:

12693.365. Geographic managed care plans that have a contract with the Department of Health Services, that contract with the program, and that are licensed by the Department of Managed Care but do not have a commercial license from the Department of Managed Care, may contract with the board for a maximum of 12 months. During this 12-month period, those plans shall be required to be in good standing with the Department of Managed Care and shall demonstrate to the board that they are making a good faith effort to obtain a commercial license from the Department of Managed Care. In their application to the program, those plans shall provide assurance of their standing with the Department of Managed Care and shall outline their plans for obtaining commercial licensure.

SEC. 188. Section 12693.37 of the Insurance Code is amended to read:

12693.37. (a) The board shall contract with a broad range of health plans in an area, if available, to ensure that subscribers have a choice from among a reasonable number and types of competing health plans. The board shall develop and make available objective criteria for health plan selection and provide adequate notice of the application process to permit all health plans a reasonable and fair opportunity to participate. The criteria and application process shall

allow participating health plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this chapter. Health plan selection shall be based on the criteria developed by the board.

(b) (1) In its selection of participating plans the board shall take all reasonable steps to assure the range of choices available to each applicant, other than a purchasing credit member, shall include plans that include in their provider networks and have signed contracts with traditional and safety net providers.

(2) Participating health plans shall be required to submit to the board on an annual basis a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to:

(A) Geographic access for the subscribers.

(B) Linguistic services.

(C) The ethnic composition of providers.

(D) The number of subscribers who selected traditional and safety net providers.

(c) (1) The board shall not rely solely on the Department of Managed Care's determination of a health plan network's adequacy or geographic access to providers in the awarding of contracts under this part. The board shall collect and review demographic, census, and other data to provide to prospective local initiatives, health plans, or specialized health plans, as defined in this act, specific provider contracting target areas with significant numbers of uninsured children in low-income families. The board shall give priority to those plans, on a county-by-county basis, that demonstrate that they have included in their prospective plan networks significant numbers of providers in these geographic areas.

(2) Targeted contracting areas are those ZIP Codes or groups of ZIP Codes or census tracts or groups of census tracts that have a percentage of uninsured children in low-income families greater than the overall percentage of uninsured children in low-income families in that county.

(d) In each geographic area, the board shall designate a community provider plan that is the participating health plan which has the highest percentage of traditional and safety net providers in its network. Subscribers selecting such a plan shall be given a family contribution discount as described in Section 12693.43.

(e) The board shall establish reasonable limits on health plan administrative costs.

SEC. 189. Section 12695.18 of the Insurance Code is amended to read:

12695.18. ''Participating health plan'' means any of the following plans which are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service

arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:

(a) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(b) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2.

(c) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).

(d) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(e) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Managed Care shall be required to meet the requirements of this part.

(f) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Managed Care shall be required to meet the requirements of this part.

SEC. 190. Section 4600.5 of the Labor Code is amended to read:

4600.5. (a) Any health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the Department of Insurance, or any entity, including, but not limited to, workers' compensation insurers and third-party administrators authorized by the administrative director under subdivision (e), may make written application to the administrative director to become certified as a health care organization to provide health care to injured employees for injuries and diseases compensable under this article.

(b) Each application for certification shall be accompanied by a reasonable fee prescribed by the administrative director, sufficient to cover the actual cost of processing the application. A certificate is valid for the period that the director may prescribe unless sooner revoked or suspended.

(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, the administrative director shall certify the plan to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Managed Care and meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace

health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Managed Care in compliance with the Knox-Keene Health Care Service Plan Act, relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees in compliance with the requirements of this code.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1 of the Health and Safety Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(d) If the health care organization is a disability insurer licensed by the Department of Insurance, and is in compliance with subdivision (d) of Sections 10133 and 10133.5 of the Insurance Code, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Insurance and meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other

measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Insurance in compliance with the Insurance Code relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(e) If the health care organization is a workers' compensation insurer, third-party administrator, or any other entity that the administrative director determines meets the requirements of Section 4600.6, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that it meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records relating to provider accessibility, peer review, utilization review, quality assurance, advertising, disclosure, medical and financial audits, and grievance systems, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(7) Complies with the following requirements:

(A) An organization certified by the administrative director under this subdivision may not provide or undertake to arrange for the provision of health care to employees, or to pay for or to reimburse any part of the cost of that health care in return for a prepaid or periodic charge paid by or on behalf of those employees.

(B) Every organization certified under this subdivision shall operate on a fee-for-service basis. As used in this section, fee for service refers to the situation where the amount of reimbursement paid by the employer to the organization or providers of health care is determined by the amount and type of health care rendered by the organization or provider of health care.

(C) An organization certified under this subdivision is prohibited from assuming risk.

(f) (1) A workers' compensation health care provider organization authorized by the Department of Corporations on December 31, 1997, shall be eligible for certification as a health care organization under subdivision (e).

(2) An entity that had, on December 31, 1997, submitted an application with the Commissioner of Corporations under Part 3.2 (commencing with Section 5150) shall be considered an applicant for certification under subdivision (e) and shall be entitled to priority in consideration of its application. The Commissioner of Corporations shall provide complete files for all pending applications to the administrative director on or before January 31, 1998.

(g) The provisions of this section shall not affect the confidentiality or admission in evidence of a claimant's medical treatment records.

(h) Charges for services arranged for or provided by health care service plans certified by this section and that are paid on a per-enrollee-periodic-charge basis shall not be subject to the schedules adopted by the administrative director pursuant to Section 5307.1.

(i) Nothing in this section shall be construed to expand or constrict any requirements imposed by law on a health care service plan or insurer when operating as other than a health care organization pursuant to this section.

(j) In consultation with interested parties, including the Department of Corporations and the Department of Insurance, the administrative director shall adopt rules necessary to carry out this section.

(k) The administrative director shall refuse to certify or may revoke or suspend the certification of any health care organization under this section if the director finds that:

(1) The plan for providing medical treatment fails to meet the requirements of this section.

(2) A health care service plan licensed by the Department of Managed Care, a workers' compensation health care provider organization authorized by the Department of Corporations, or a carrier licensed by the Department of Insurance is not in good standing with its licensing agency.

(3) Services under the plan are not being provided in accordance with the terms of a certified plan.

(*l*) (1) When an injured employee requests chiropractic treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of a chiropractor pursuant to guidelines for chiropractic care established by paragraph (2). Within five working days of the employee's request to see a chiropractor, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated chiropractor for work-related injuries that are within the guidelines for chiropractic care established by paragraph (2). Chiropractic care rendered in accordance with guidelines for chiropractic care established pursuant to paragraph (2) shall be provided by duly licensed chiropractors affiliated with the plan.

(2) The health care organization shall establish guidelines for chiropractic care in consultation with affiliated chiropractors who are participants in the health care organization's utilization review process for chiropractic care, which may include qualified medical evaluators knowledgeable in the treatment of chiropractic conditions. The guidelines for chiropractic care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated chiropractor for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of chiropractic care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for chiropractic care in accordance with the health care organization's guidelines for chiropractic care established by paragraph (2).

Chiropractic utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process

for chiropractic care. Chiropractors affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of chiropractic care for work-related injuries, the review shall include review by a chiropractor affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to chiropractic care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for chiropractic care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

(m) Individually identifiable medical information on patients submitted to the division shall not be subject to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(n) (1) When an injured employee requests acupuncture treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of an acupuncturist pursuant to guidelines for acupuncture care established by paragraph (2). Within five working days of the employee's request to see an acupuncturist, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated acupuncturist for work-related injuries that are within the guidelines for acupuncture care established by paragraph (2). Acupuncture care rendered in accordance with guidelines for acupuncture care established pursuant to paragraph (2) shall be provided by duly licensed acupuncturists affiliated with the plan.

(2) The health care organization shall establish guidelines for acupuncture care in consultation with affiliated acupuncturists who are participants in the health care organization's utilization review process for acupuncture care, which may include qualified medical evaluators. The guidelines for acupuncture care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated acupuncturist for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of acupuncture care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for acupuncture care in accordance with the health care organization's guidelines for acupuncture care established by paragraph (2).

Acupuncture utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for acupuncture care. Acupuncturists affiliated with the plan shall

have access to the health care organization's provider appeals process and, in the case of acupuncture care for work-related injuries, the review shall include review by an acupuncturist affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to acupuncture care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for acupuncture care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

SEC. 191. Section 830.3 of the Penal Code is amended to read:

830.3. The following persons are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest pursuant to Section 836 of the Penal Code as to any public offense with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of that offense, or pursuant to Section 8597 or 8598 of the Government Code. These peace officers may carry firearms only if authorized and under those terms and conditions as specified by their employing agencies:

(a) Persons employed by the Division of Investigation of the Department of Consumer Affairs and investigators of the Medical Board of California and the Board of Dental Examiners, who are designated by the Director of Consumer Affairs, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 160 of the Business and Professions Code. The Director of Consumer Affairs shall designate as peace officers seven persons who shall at the time of their designation be assigned to the investigations unit of the Board of Dental Examiners.

(b) Voluntary fire wardens designated by the Director of Forestry and Fire Protection pursuant to Section 4156 of the Public Resources Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 4156 of that code.

(c) Employees of the Department of Motor Vehicles designated in Section 1655 of the Vehicle Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 1655 of that code.

(d) Investigators of the California Horse Racing Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of Chapter 4 (commencing with Section 19400) of Division 8 of the Business and Professions Code and Chapter 10 (commencing with Section 330) of Title 9 of Part 1 of this code.

(e) The State Fire Marshal and assistant or deputy state fire marshals appointed pursuant to Section 13103 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 13104 of that code.

(f) Inspectors of the food and drug section designated by the chief pursuant to subdivision (a) of Section 106500 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 106500 of that code.

(g) All investigators of the Division of Labor Standards Enforcement designated by the Labor Commissioner, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Section 95 of the Labor Code.

(h) All investigators of the State Departments of Health Services, Social Services, Mental Health, Developmental Services, and Alcohol and Drug Programs, the Department of Toxic Substances Control, the Office of Statewide Health Planning and Development, and the Public Employees' Retirement System, provided that the primary duty of these peace officers shall be the enforcement of the law relating to the duties of his or her department, or office. Notwithstanding any other provision of law, investigators of the Public Employees' Retirement System shall not carry firearms.

(i) The Chief of the Bureau of Fraudulent Claims of the Department of Insurance and those investigators designated by the chief, provided that the primary duty of those investigators shall be the enforcement of Section 550.

(j) Employees of the Department of Housing and Community Development designated under Section 18023 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 18023 of that code.

(k) Investigators of the office of the Controller, provided that the primary duty of these investigators shall be the enforcement of the law relating to the duties of that office. Notwithstanding any other law, except as authorized by the Controller, the peace officers designated pursuant to this subdivision shall not carry firearms.

(*l*) Investigators of the Department of Corporations designated by the Commissioner of Corporations, provided that the primary duty of these investigators shall be the enforcement of the provisions of law administered by the Department of Corporations. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(m) Persons employed by the Contractors' State License Board designated by the Director of Consumer Affairs pursuant to Section 7011.5 of the Business and Professions Code, provided that the primary duty of these persons shall be the enforcement of the law as

that duty is set forth in Section 7011.5, and in Chapter 9 (commencing with Section 7000) of Division 3, of that code. The Director of Consumer Affairs may designate as peace officers not more than three persons who shall at the time of their designation be assigned to the special investigations unit of the board. Notwithstanding any other provision of law, the persons designated pursuant to this subdivision shall not carry firearms.

(n) The chief and coordinators of the Law Enforcement Division of the Office of Emergency Services.

(o) Investigators of the office of the Secretary of State designated by the Secretary of State, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Chapter 3 (commencing with Section 8200) of Division 1 of Title 2 of, and Section 12172.5 of, the Government Code. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(p) The Deputy Director for Security designated by Section 8880.38 of the Government Code, and all lottery security personnel assigned to the California State Lottery and designated by the director, provided that the primary duty of any of those peace officers shall be the enforcement of the laws related to assuring the integrity, honesty, and fairness of the operation and administration of the California State Lottery.

(q) Investigators employed by the Investigation Division of the Employment Development Department designated by the director of the department, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 317 of the Unemployment Insurance Code.

Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(r) The chief and assistant chief of museum security and safety of the California Science Center, as designated by the executive director pursuant to Section 4108 of the Food and Agricultural Code, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 4108 of the Food and Agricultural Code.

(s) Employees of the Franchise Tax Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of the law as set forth in Chapter 9 (commencing with Section 19701) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(t) Notwithstanding any other provision of this section, a peace officer authorized by this section shall not be authorized to carry firearms by his or her employing agency until that agency has adopted a policy on the use of deadly force by those peace officers, and until those peace officers have been instructed in the employing agency’s policy on the use of deadly force.

Every peace officer authorized pursuant to this section to carry firearms by his or her employing agency shall qualify in the use of the firearms at least every six months.

(u) Investigators of the Department of Managed Care designated by the Director of the Department of Managed Care, provided that the primary duty of these investigators shall be the enforcement of the provisions of laws administered by the Director of the Department of Managed Care. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

SEC. 192. Section 5777 of the Welfare and Institutions Code is amended to read:

5777. (a) (1) Except as otherwise specified in this part, a contract entered into pursuant to this part shall include a provision that the mental health plan contractor shall bear the financial risk for the cost of providing medically necessary mental health services to Medi-Cal beneficiaries irrespective of whether the cost of those services exceeds the payment set forth in the contract. If the expenditures for services do not exceed the payment set forth in the contract, the mental health plan contractor shall report the unexpended amount to the department, but shall not be required to return the excess to the department.

(2) If the mental health plan is not the county's, the mental health plan may not transfer the obligation for any mental health services to Medi-Cal beneficiaries to the county. The mental health plan may purchase services from the county. The mental health plan shall establish mutually agreed-upon protocols with the county that clearly establish conditions under which beneficiaries may obtain non-Medi-Cal reimbursable services from the county. Additionally, the plan shall establish mutually agreed-upon protocols with the county for the conditions of transfer of beneficiaries who have lost Medi-Cal eligibility to the county for care under Part 2 (commencing with Section 5600), Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850).

(3) The mental health plan shall be financially responsible for ensuring access and a minimum required scope of benefits, consistent with state and federal requirements, to the services to the Medi-Cal beneficiaries of that county regardless of where the beneficiary resides. The department shall require that the definition of medical necessity used, and the minimum scope of benefits offered, by each mental health contractor be the same, except to the extent that any variations receive prior federal approval and are consistent with state and federal statutes and regulation.

(b) Any contract entered into pursuant to this part may be renewed if the plan continues to meet the requirements of this part, regulations promulgated pursuant thereto, and the terms and conditions of the contract. Contract renewal shall be on an annual

basis. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may base the decision to renew on timely completion of a mutually agreed upon plan of correction of any deficiencies, submissions of required information in a timely manner, or other conditions of the contract.

(c) (1) The obligations of the mental health plan shall be changed only by contract or contract amendment.

(2) A change may be made during a contract term or at the time of contract renewal, where there is a change in obligations required by federal or state law or when required by a change in the interpretation or implementation of any law or regulation. To the extent permitted by federal law and except as provided under subdivision (r) of Section 5778, if any change in obligations occurs that affects the cost to the mental health plan of performing under the terms of its contract, the department may reopen contracts to negotiate the state General Fund allocation to the mental health plan under Section 5778, if the mental health plan is reimbursed through a fee-for-service payment system, or the capitation rate to the mental health plan under Section 5779, if the mental health plan is reimbursed through a capitated rate payment system. During the time period required to redetermine the allocation or rate, payment to the mental health plan of the allocation or rate in effect at the time the change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which the change is effective.

(3) To the extent permitted by federal law, either the department or the mental health plan may request that contract negotiations be reopened during the course of a contract due to substantial changes in the cost of covered benefits that result from an unanticipated event.

(d) The department shall immediately terminate a contract when the director finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons shall be subject to reasonable notice of the department's intent to take that action and notification of affected beneficiaries. The plan may request a public hearing by the Office of Administrative Hearings.

(e) A plan may terminate its contract in accordance with the provisions in the contract. The plan shall provide written notice to the department at least 180 days prior to the termination or nonrenewal of the contract.

(f) Upon the request of the Director of Mental Health, the Director of the Department of Managed Care may exempt a mental health plan contractor or a capitated rate contract from the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). These exemptions may be subject to conditions the

director deems appropriate. Nothing in this part shall be construed to impair or diminish the authority of the Director of the Department of Managed Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in this part be construed to reduce or otherwise limit the obligation of a mental health plan contractor licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Care promulgated thereunder. The Director of Mental Health, in consultation with the Director of the Department of Managed Care, shall analyze the appropriateness of licensure or application of applicable standards of the Knox-Keene Health Care Service Plan Act of 1975.

(g) The department, pursuant to an agreement with the State Department of Health Services, shall provide oversight to the mental health plans to ensure quality, access, and cost efficiency. At a minimum, the department shall, through a method independent of any agency of the mental health plan contractor, monitor the level and quality of services provided, expenditures pursuant to the contract, and conformity with federal and state law.

(h) County employees implementing or administering a mental health plan act in a discretionary capacity when they determine whether or not to admit a person for care or to provide any level of care pursuant to this part.

(i) If a county chooses to discontinue operations as the local mental health plan, the new plan shall give reasonable consideration to affiliation with nonprofit community mental health agencies that were under contract with the county and that meet the mental health plan's quality and cost efficiency standards.

(j) Nothing in this part shall be construed to modify, alter, or increase the obligations of counties as otherwise limited and defined in Chapter 3 (commencing with Section 5700) of Part 2. The county's maximum obligation for services to persons not eligible for Medi-Cal shall be no more than the amount of funds remaining in the mental health subaccount pursuant to Sections 17600, 17601, 17604, 17605, 17606, and 17609 after fulfilling the Medi-Cal contract obligations.

SEC. 193. Section 9541 of the Welfare and Institutions Code is amended to read:

9541. (a) The Legislature finds and declares that the purpose of the Health Insurance Counseling and Advocacy Program is to provide Medicare beneficiaries and those imminent of becoming eligible for Medicare with counseling and advocacy as to Medicare, private health insurance, and related health care coverage plans, on a statewide basis, and preserving service integrity.

(b) The department shall be responsible for, but not limited to, doing both of the following:

(1) To act as a clearinghouse for information and materials relating to Medicare, managed care, health and long-term care related life and disability insurance, and related health care coverage plans.

(2) To develop additional information and materials relating to Medicare, managed care, and health and long-term care related life and disability insurance, and related health care coverage plans, as necessary.

(c) Notwithstanding the terms and conditions of the contracts, direct services contractors shall be responsible for, but not limited to, all of the following:

(1) Community education to the public on Medicare, long-term care planning, private health and long-term care insurance, managed care, and related health care coverage plans.

(2) Counseling and informal advocacy with respect to Medicare, long-term care planning, private health and long-term care insurance, managed care, and related health care coverage plans.

(3) Referral services for legal representation or legal representation with respect to Medicare appeals, Medicare related managed care appeals, and life and disability insurance problems. Legal services provided under this program shall be subject to the understanding that the legal representation and legal advocacy shall not include the filing of lawsuits against private insurers or managed health care plans. In the event that legal services are contracted for by the agency separately from counseling and education services, a formal system of coordination and referral from counseling services to legal services shall be established and maintained.

(4) Educational services supporting long-term care educational activities aimed at the general public, employers, employee groups, senior organizations, and other groups expressing interest in long-term care planning issues.

(5) Educational services emphasizing the importance of long-term care planning, promotion of self-reliance and independence, and options for long-term care.

(6) To the extent possible, support additional emphasis on community educational activities that would provide for announcements on television and in other media describing the limited nature of Medicare, the need for long-term care planning, the function of long-term care insurance, and the availability of counseling and educational literature on those subjects.

(7) Recruitment, training, coordination, and registration, with the department, of health insurance counselors, including a large contingent of volunteer counselors designed to expand services as broadly as possible.

(8) A systematic means of capturing and reporting all required community-based services program data, as specified by the department.

(d) Participants who volunteer their time for the health insurance counseling and advocacy program may be reimbursed for expenses incurred, as specified by the department.

(e) The department, the Department of Managed Care, and the Department of Insurance shall jointly develop interagency procedures for referring and investigating suspected instances of misrepresentation in advertising or sales of services provided by Medicare, managed health care plans, and life and disability insurers and agents.

(f) (1) No health insurance counselor shall provide counseling services under this chapter, unless he or she is registered with the department.

(2) No registered volunteer health insurance counselor shall be liable for his or her negligent act or omission in providing counseling services under this chapter. No immunity shall apply to health insurance counselors for any grossly negligent act or omission or intentional misconduct.

(3) No registered volunteer health insurance counselor shall be liable to any insurance agent, broker, employee thereof, or similarly situated person, for defamation, trade libel, slander, or similar actions based on statements made by the counselor when providing counseling, unless a statement was made with actual malice.

(4) Prior to providing any counseling services, health insurance counselors shall disclose, in writing, to recipients of counseling services pursuant to this chapter that the counselors are acting in good faith to provide information about health insurance policies and benefits on a volunteer basis, but that the information shall not be construed to be legal advice, and that the counselors are, generally, not liable unless their acts and omissions are grossly negligent or there is intentional misconduct on the part of the counselor.

(5) The department shall not register any applicant under this section unless he or she has completed satisfactorily training which is approved by the department, and which shall consist of not less than 24 hours of training that shall include, but is not limited to, all of the following subjects:

(A) Medicare.

(B) Life and disability insurance.

(C) Managed care.

(D) Retirement benefits and principles of long-term care planning.

(E) Counseling skills.

(F) Any other subject or subjects determined by the department to be necessary to the provision of counseling services under this chapter.

(6) The department shall not register any applicant under this section unless he or she has completed all training requirements and has served an internship of cocounseling of not less than 10 hours with

an experienced counselor and is determined by the local program manager to be capable of discharging the responsibilities of a counselor. An applicant shall sign a conflict of interest and confidentiality agreement, as specified by the department.

(7) A counselor shall not continue to provide health insurance counseling services unless he or she has received continuing education and training, in a manner prescribed by the department, on Medicare, managed care, life and disability insurance, and other subjects during each calendar year.

SEC. 194. Section 14087.32 of the Welfare and Institutions Code is amended to read:

14087.32. (a) Commencing on the date the authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until a commission established pursuant to Section 14087.31 is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, all of the following shall apply:

(1) The commission may select and design its automated management information system. The department, in cooperation with the commission, prior to making capitated payments, shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the commission, and any other information that is generally required by the department in its contracts with other health care service plans.

(2) In addition to the reports required by the Department of Managed Care under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the rules of the Director of the Department of Managed Care promulgated thereunder, a commission established pursuant to Section 14087.31 shall provide, on a monthly basis, to the department, the Department of Managed Care, and the members of the commission, a copy of the automated report described in paragraph (1) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets of liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association or community clinic, which has contracted with the authority to provide health care services.

(3) In addition to the reporting and notification obligations the commission has under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the chief executive officer or director of the commission shall immediately notify the department, the Department of Managed Care, and the members of

the commission, in writing, of any fact or facts that, in the chief executive officer's or director's reasonable and prudent judgment, is likely to result in the commission being unable to meet its financial obligations to health care providers or to other parties. The written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions which will be taken to address the anticipated consequences.

(4) The Department of Managed Care shall not, in any way, waive or vary, nor shall the department request the Department of Managed Care to waive or vary, the tangible net equity requirements for a commission under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, after three years from the date of commencement of capitated payments to the commission. Until the commission is in compliance with all of the tangible net equity requirements under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the rules of the Director of the Department of Managed Care adopted thereunder, the commission shall develop a stop-loss program appropriate to the risks of the commission, which program shall be satisfactory to both department and the Department of Managed Care.

(5) (A) If the commission votes to file a petition of bankruptcy, or the county board of supervisors notifies the department of its intent to terminate the commission, the department shall immediately transfer the authority's Medi-Cal beneficiaries as follows:

(i) To other managed care contractors, when available, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees.

(ii) To the extent that other managed care contractors are unavailable or the department determines that it is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary.

(B) Beneficiary eligibility for Medi-Cal shall not be affected by actions taken pursuant to subparagraph (A).

(C) Beneficiaries who have been or who are scheduled to be transferred to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another

managed care system, if one is available, in full compliance with the federal freedom-of-choice requirements.

(6) (A) A commission established pursuant to Section 14087.31 shall submit to a review of financial records when the department determines, based on data reported by the commission or otherwise, that the commission will not be able to meet its financial obligations to health care providers contracting with the commission. Where the review of financial records determines that the commission will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the Director of Health Services shall immediately terminate the contract between the commission and the state, and immediately transfer the commission's Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers.

(B) The action of the Director of Health Services pursuant to subparagraph (A) shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action.

(C) Beneficiaries who have been or who are scheduled to be transferred under paragraph (5) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(7) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a matter that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the commission shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the commission's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(8) In the event a commission is terminated, files for bankruptcy, or otherwise no longer functions for the purpose for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the commission.

(9) Nothing in this section shall be construed to impair or diminish the authority of the Director of the Department Managed Care under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, nor shall anything in the section be construed to reduce or otherwise limit the obligation of a commission licensed as a health care service plan to comply with the requirements of Chapter 2.2 (commencing with Section 1340) of

Division 2 of the Health and Safety Code and the rules of the Director of the Department of Managed Care adopted thereunder.

(10) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the Public Records Act (Chapter 5 (commencing with Section 65250) of Division 7 of Title 1 of the Government Code), including but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the commission is required to prepare, produce or submit pursuant to this section.

SEC. 195. Section 14087.36 of the Welfare and Institutions Code is amended to read:

14087.36. (a) The following definitions shall apply for purposes of this section:

(1) ''County'' means the City and County of San Francisco.

(2) ''Board'' means the Board of Supervisors of the City and County of San Francisco.

(3) ''Department'' means the State Department of Health Services.

(4) ''Governing body'' means the governing body of the health authority.

(5) ''Health authority'' means the separate public agency established by the board of supervisors to operate a health care system in the county and to engage in the other activities authorized by this section.

(b) The Legislature finds and declares that it is necessary that a health authority be established in the county to arrange for the provision of health care services in order to meet the problems of the delivery of publicly assisted medical care in the county, to enter into a contract with the department under Article 2.97 (commencing with Section 14093), or to contract with a health care service plan on terms and conditions acceptable to the department, and to demonstrate ways of promoting quality care and cost efficiency.

(c) The county may, by resolution or ordinance, establish a health authority to act as and be the local initiative component of the Medi-Cal state plan pursuant to regulations adopted by the department. If the board elects to establish a health authority, all rights, powers, duties, privileges, and immunities vested in a county under Article 2.8 (commencing with Section 14087.5) and Article 2.97 (commencing with Section 14093) shall be vested in the health authority. The health authority shall have all power necessary and appropriate to operate programs involving health care services, including, but not limited to, the power to acquire, possess, and dispose of real or personal property, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to take all actions and engage in all public and private

business activities, subject to any applicable licensure, as permitted a health care service plan pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(d) (1) (A) The health authority shall be considered a public entity separate and distinct from the county and shall file the statement required by Section 53051 of the Government Code. The health authority shall have primary responsibility to provide the defense and indemnification required under Division 3.6 (commencing with Section 810) of Title 1 of the Government Code for employees of the health authority who are employees of the county. The health authority shall provide insurance under terms and conditions required by the county in order to satisfy its obligations under this section.

(B) For purposes of this paragraph, ''employee'' shall have the same meaning as set forth in Section 810.2 of the Government Code.

(2) The health authority shall not be considered to be an agency, division, department, or instrumentality of the county and shall not be subject to the personnel, procurement, or other operational rules of the county.

(3) Notwithstanding any other provision of law, any obligations of the health authority, statutory, contractual, or otherwise, shall be the obligations solely of the health authority and shall not be the obligations of the county, unless expressly provided for in a contract between the authority and the county, nor of the state.

(4) Except as agreed to by contract with the county, no liability of the health authority shall become an obligation of the county upon either termination of the health authority or the liquidation or disposition of the health authority's remaining assets.

(e) (1) To the full extent permitted by federal law, the department and the health authority may enter into contracts to provide or arrange for health care services for any or all persons who are eligible to receive benefits under the Medi-Cal program. The contracts may be on an exclusive or nonexclusive basis, and shall include payment provisions on any basis negotiated between the department and the health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter 18 (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, individuals employed by public agencies and private businesses, and uninsured or indigent individuals.

(2) Notwithstanding paragraph (1), or subdivision (f), the health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act

of 1975 under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, including tangible net equity requirements applicable to a licensed health care service plan. This limitation shall not preclude the health authority from enrolling persons pursuant to the county's obligations under Section 17000, or from enrolling county employees.

(f) The board of supervisors may transfer responsibility for administration of county-provided health care services to the health authority for the purpose of service of populations including uninsured and indigent persons, subject to the provisions of any ordinances or resolutions passed by the county board of supervisors. The transfer of administrative responsibility for those health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter 18 (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, and individuals employed by public agencies and private businesses.

(g) Upon creation, the health authority may borrow from the county and the county may lend the authority funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations or perform the activities of the health authority. Notwithstanding any other provision of law, both the county and the health authority shall be eligible to receive funding under subdivision (p) of Section 14163.

(h) The county may terminate the health authority, but only by an ordinance approved by a two-thirds affirmative vote of the full board.

(i) Prior to the termination of the health authority, the county shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority's records within 30 days of notification to determine the liabilities and assets of the health authority. The department shall report its findings to the county and to the Department of Managed Care within 10 days of completion of the audit. The county shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority's assets, and present the plan to the department and the Department of Managed Care within 30 days upon receipt of these findings.

(j) Any assets of the health authority derived from the contract entered into between the state and the authority pursuant to Article 2.97 (commencing with Section 14093), after payment of the liabilities of the health authority, shall be disposed of pursuant to the contract.

(k) (1) The governing body shall consist of 18 voting members, 14 of whom shall be appointed by resolution or ordinance of the board as follows:

(A) One member shall be a member of the board or any other person designated by the board.

(B) One member shall be a person who is employed in the senior management of a hospital not operated by the county or the University of California and who is nominated by the San Francisco Section of the Westbay Hospital Conference or any successor organization, or if no such successor organization, a person who shall be nominated by the Hospital Council of Northern and Central California.

(C) Two members, one of whom shall be a person employed in the senior management of San Francisco General Hospital and one of whom shall be a person employed in the senior management of St. Luke's Hospital (San Francisco). If San Francisco General Hospital or St. Luke's Hospital, at the end of the term of the person appointed from its senior management, is not designated as a disproportionate share hospital, and if the governing body, after providing an opportunity for comment by the Westbay Hospital Conference, or any successor organization, determines that the hospital no longer serves an equivalent patient population, the governing body may, by a two-thirds vote of the full governing body, select an alternative hospital to nominate a person employed in its senior management to serve on the governing body. Alternatively, the governing body may approve a reduction in the number of positions on the governing body as set forth in subdivision (p).

(D) Two members shall be employees in the senior management of either private nonprofit community clinics or a community clinic consortium, nominated by the San Francisco Community Clinic Consortium, or any successor organization.

(E) Two members shall be physicians, nominated by the San Francisco Medical Society, or any successor organization.

(F) One member shall be nominated by the San Francisco Labor Council, or any successor organization.

(G) Two members shall be persons nominated by the beneficiary committee of the health authority, at least one of whom shall, at the time of appointment and during the person's term, be a Medi-Cal beneficiary.

(H) Two members shall be persons knowledgeable in matters relating to either traditional safety net providers, health care organizations, the Medi-Cal program, or the activities of the health authority, nominated by the program committee of the health authority.

(I) One member shall be a person nominated by the San Francisco Pharmacy Leadership Group, or any successor organization.

(2) One member, selected to fulfill the appointments specified in subparagraph (A), (G), or (H) shall, in addition to representing his or her specified organization or employer, represent the discipline of nursing, and shall possess or be qualified to possess a registered nursing license.

(3) The initial members appointed by the board under the subdivision shall be, to the extent those individuals meet the qualifications set forth in this subdivision and are willing to serve, those persons who are members of the steering committee created by the county to develop the local initiative component of the Medi-Cal state plan in San Francisco. Following the initial staggering of terms, each of those members shall be appointed to a term of three years, except the member appointed pursuant to subparagraph (A) of paragraph (1), who shall serve at the pleasure of the board. At the first meeting of the governing body, the members appointed pursuant to this subdivision shall draw lots to determine seven members whose initial terms shall be for two years. Each member shall remain in office at the conclusion of that member's term until a successor member has been nominated and appointed.

(*l*) In addition to the requirements of subdivision (k), one member of the governing body shall be appointed by the Mayor of the City of San Francisco to serve at the pleasure of the mayor, one member shall be the county's director of public health or designee, who shall serve at the pleasure of that director, one member shall be the Chancellor of the University of California at San Francisco or his or her designee, who shall serve at the pleasure of the chancellor, and one member shall be the county director of mental health or his or her designee, who shall serve at the pleasure of that director.

(m) There shall be one nonvoting member of the governing body who shall be appointed by, and serve at the pleasure of, the health commission of the county.

(n) Each person appointed to the governing body shall, throughout the member's term, either be a resident of the county or be employed within the geographic boundaries of the county.

(o) (1) The composition of the governing body and nomination process for appointment of its members shall be subject to alteration upon a two-thirds vote of the full membership of the governing body. This action shall be concurred in by a resolution or ordinance of the county.

(2) Notwithstanding paragraph (1), no alteration described in that paragraph shall cause the removal of a member prior to the expiration of that member's term.

(p) A majority of the members of the governing body shall constitute a quorum for the transaction of business, and all official acts of the governing body shall require the affirmative vote of a majority of the members present and voting. However, no official shall be approved with less than the affirmative vote of six members of the

governing body, unless the number of members prohibited from voting because of conflicts of interest precludes adequate participation in the vote. The governing body may, by a two-thirds vote adopt, amend, or repeal rules and procedures for the governing body. Those rules and procedures may require that certain decisions be made by a vote that is greater than a majority vote.

(q) For purposes of Section 87103 of the Government Code, members appointed pursuant to subparagraphs (B) to (E), inclusive, of paragraph (1) of subdivision (k) represent, and are appointed to represent, respectively, the hospitals, private nonprofit community clinics, and physicians that contract with the health authority, or the health care service plan with which the health authority contracts, to provide health care services to the enrollees of the health authority or the health care service plan. Members appointed pursuant to subparagraphs (F) and (G) of paragraph (1) of subdivision (k) represent and are appointed to represent, respectively, the health care workers and enrollees served by the health authority or its contracted health care service plan, and traditional safety net and ancillary providers and other organizations concerned with the activities of the health authority.

(r) A member of the governing body may be removed from office by the board by resolution or ordinance, only upon the recommendation of the health authority, and for the following reasons:

(1) Failure to retain the qualifications for appointment specified in subdivisions (k) and (n).

(2) Death or a disability that substantially interferes with the member's ability to carry out the duties of office.

(3) Conviction of any felony or a crime involving corruption.

(4) Failure of the member to discharge legal obligations as a member of a public agency.

(5) Substantial failure to perform the duties of office, including, but not limited to, unreasonable absence from meetings. The failure to attend three meetings in a row of the governing body, or a majority of the meetings in the most recent calendar year, may be deemed to be unreasonable absence.

(s) Any vacancy on the governing body, however created, shall be filled for the unexpired term by the board by resolution or ordinance. Each vacancy shall be filled by an individual having the qualifications of his or her predecessor, nominated as set forth in subdivision (k).

(t) The chair of the authority shall be selected by, and serve at the pleasure of, the governing body.

(u) The health authority shall establish all of the following:

(1) A beneficiary committee to advise the health authority on issues of concern to the recipients of services.

(2) A program committee to advise the health authority on matters relating to traditional safety net providers, ancillary

providers, and other organizations concerned with the activities of the health authority.

(3) Any other committees determined to be advisable by the health authority.

(v) (1) Notwithstanding any provision of state or local law, including, but not limited to, the county charter, a member of the health authority shall not be deemed to be interested in a contract entered into by the authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code, or within the meaning of conflict-of-interest restrictions in the county charter, if all of the following apply:

(A) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(B) The member discloses the interest to the health authority and abstains from voting on the contract.

(C) The health authority notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(D) The member has an interest in or was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(E) The contract authorizes the member or the organization the member has an interest in or represents to provide services to beneficiaries under the authority's program or administrative services to the authority.

(2) In addition, no person serving as a member of the governing body shall, by virtue of that membership, be deemed to be engaged in activities that are inconsistent, incompatible, or in conflict with their duties as an officer or employee of the county or the University of California, or as an officer or an employee of any private hospital, clinic, or other health care organization. The membership shall not be deemed to be in violation of Section 1126 of the Government Code.

(w) Notwithstanding any other provision of law, those records of the health authority and of the health county that reveal the authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, or the health authority's peer review proceedings shall not be required to be disclosed pursuant to the California Public Records Act, Chapter 5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed,

the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(x) Notwithstanding any other provision of law, the health authority may meet in closed session to consider and take action on peer review proceedings and on matters pertaining to contracts and to contract negotiations by the health authority's staff with providers of health care services concerning all matters relating to rates of payment. However, a decision as to whether to enter into, amend the services provisions of, or terminate, other than for reasons based upon peer review, a contract with a provider of health care services, shall be made in open session.

(y) The health authority shall be deemed to be a public agency for purposes of all grant programs and other funding and loan guarantee programs.

(z) Contracts under this article between the State Department of Health Services and the health authority shall be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(aa) (1) The county controller or his or her designee, at intervals the county controller deems appropriate, shall conduct a review of the fiscal condition of the health authority, shall report the findings to the health authority and the board, and shall provide a copy of the findings to any public agency upon request.

(2) Upon the written request of the county controller, the health authority shall provide full access to the county controller all health authority records and documents as necessary to allow the county controller or designee to perform the activities authorized by this subdivision.

(bb) A Medi-Cal recipient receiving services through the health authority shall be deemed to be a subscriber or enrollee for purposes of Section 1379 of the Health and Safety Code.

SEC. 196. Section 14087.37 of the Welfare and Institutions Code is amended to read:

14087.37. Commencing on the date that a health authority established pursuant to Section 14087.35 or 14087.36 first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, the following provisions shall apply:

(a) The health authority may select and design its automated management information system, but the department, in cooperation with the health authority, prior to making capitated payments shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the health authority and any other

information generally required by the department in its contracts with health care service plans.

(b) In addition to the reports required by the Department of Managed Care under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Care promulgated thereunder, the health authority shall provide on a monthly basis to the department, the Department of Managed Care, and the members of the health authority, a copy of the automated report described in subdivision (a) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets or liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association, or community clinic, that has contracted with the health authority to provide health care services.

(c) In addition to the reporting and notification obligations the health authority has under the Knox-Keene Health Care Service Plan Act of 1975, the chief executive officer or director of the health authority shall immediately notify the department, the Department of Managed Care, and the members of the health authority in writing of any fact or facts that, in the chief executive officers' or director's reasonable and prudent judgment, is likely to result in the health authority being unable to meet its financial obligations to health care providers or to other parties. Written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions that will be taken to address the anticipated consequences.

(d) The Department of Managed Care shall not waive or vary, nor shall the department request the Department of Managed Care to waive or vary, the tangible net equity requirements for a health authority under the Knox-Keene Health Care Service Plan Act of 1975 after three years from the date of commencement of capitated payments to the health authority. Until the time the health authority is in compliance with all of the tangible net equity requirements under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Care promulgated thereunder, the health authority shall develop a stop-loss program appropriate to the risks of the health authority. The program shall be satisfactory to both the department and the Department of Managed Care.

(e) In the event that the health authority votes to file a petition of bankruptcy, or the board of supervisors notifies the department of its intent to terminate the health authority, the department shall immediately convert the health authority's Medi-Cal beneficiaries to either of the following:

(1) To other managed care contractors when available, provided those contractors are able to demonstrate that they can absorb the

increased enrollment without detriment to the provision of health care services to their existing enrollees.

(2) To the extent that other managed care contractors are unavailable or the department determines that the action is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or if the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another managed care system, if one is available, in full compliance with the federal freedom-of-choice requirements.

(f) The health authority shall submit to a review of financial records when the department determines, based on data reported by the health authority or otherwise, that the health authority will not be able to meet its financial obligations to health care providers contracting with the health authority. Where the review of financial records determines that the health authority will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the director shall immediately terminate the contract between the health authority and the state, and immediately convert the health authority Medi-Cal beneficiaries in accordance with subdivision (e) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers. The action of the director shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted under subdivision (e) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(g) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a manner that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the health authority shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the health authority's provider network and administrative structure are able to provide

appropriate and timely services to beneficiaries and to participating providers.

(h) In the event a health authority is terminated, files for bankruptcy, or otherwise no longer functions for the purpose for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the health authority.

(i) Nothing in this subdivision shall be construed to impair or diminish the authority of the Director of the Department of Managed Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in the section be construed to reduce or otherwise limit the obligation of a health authority licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Care promulgated thereunder.

SEC. 197. Section 14087.38 of the Welfare and Institutions Code is amended to read:

14087.38. (a) (1) In counties selected by the director with the concurrence of the county, a special county health authority may be established in order to meet the problems of delivery of publicly assisted medical care in each county, and to demonstrate ways of promoting quality care and cost efficiency. Nothing in this section shall be construed to preclude the department from expanding Medi-Cal managed care in ways other than those provided for in this section, including, but not limited to, the establishment of a public benefit corporation as set forth in Section 5110 of the Corporations Code.

(2) For purposes of this section ''health authority'' means an entity separate from the county that meets the requirements of state and federal law and the quality, cost, and access criteria established by the department.

(b) The board of supervisors of a county described in subdivision (a) may, by ordinance, establish a health authority to negotiate and enter into contracts authorized by Section 14087.3, and to arrange for the provision of health care services provided pursuant to this chapter. If the board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county contracting with the department under this article shall be vested in the health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, those entitled to coverage under other publicly supported programs, those employed by public agencies or private businesses, and uninsured or indigent individuals.

(c) The enabling ordinance shall specify the membership of the governing board of the health authority, the qualifications for individual members, the manner of appointment, selection, or removal of board members, and how long they shall serve, and any other matters the board of supervisors deems necessary or convenient for the conduct of the health authority's activities. Members of the governing board shall be appointed by the board of supervisors to represent the interests of the county, the general public, beneficiaries, physicians, hospitals, clinics, and other nonphysician health care providers. The health authority so established shall be considered an entity separate from the county, shall file a statement required by Section 53051 of the Government Code, and shall have the power to acquire, possess, and dispose of real or personal property, as necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, and to sue or be sued. Any obligations of a health authority, statutory, contractual, or otherwise, shall be obligations solely of the health authority and shall not be the obligations of the county or of the state.

(d) Upon creation, the health authority may borrow from the county, and the county may lend the health authority funds or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(e) Notwithstanding any other provision of law, both the county and the health authority shall be eligible to receive funding under subdivision (p) of Section 14163, and the health authority shall be considered to have satisfied the requirements of that subdivision.

(f) The health authority shall be deemed to be a public agency that is a unit of local government for purposes of all grant programs and other funding and loan guarantee programs.

(g) It is the intent of the Legislature that if a health authority is formed pursuant to this section, the county shall, with respect to its medical facilities and programs, occupy no greater or lesser status than any other health care provider in negotiating with the health authority for contracts to provide health care services. Nothing in this subdivision shall be construed to interfere with or limit the health authority in giving preference in negotiating to disproportionate share hospitals or other providers of health care to medically indigent or uninsured individuals.

(h) Notwithstanding any other provisions of law, a member of the governing board of the health authority shall not be deemed to be interested in a contract entered into by the health authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all the following apply:

(1) The member was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations, or beneficiaries.

(2) The contract authorizes the member or the organization the member represents to provide services to beneficiaries under the health authority's programs.

(3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the member was appointed to represent.

(4) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(5) The member discloses the interest to the health authority and abstains from voting on the contract.

(6) The governing board notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(i) All claims for money or damages against the health authority shall be governed by Part 3 (commencing with Section 900) and Part 4 (commencing with Section 940) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that expressly apply to the health authority.

(j) The health authority, members of its governing board, and its employees, are protected by the immunities applicable to public entities and public employees governed by Part 1 (commencing with Section 810) and Part 2 (commencing with Section 814) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that apply expressly to the health authority.

(k) Notwithstanding any other provision of law, except as otherwise provided in this section, a county shall not be liable for any act or omission of the health authority.

(*l*) The transfer of responsibility for health care services to the health authority shall not relieve the county of its responsibility for indigent care pursuant to Section 17000.

(m) Notwithstanding any other provision of law, the governing board of the health authority may meet in closed session to consider and take action on matters pertaining to contracts, and to contract negotiations by health authority staff with providers of health care services concerning all matters related to rates of payment.

(n) Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of, and Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of, the Government Code, or any other provision of law, any peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the health authority authorized by this section, may, at its

discretion and without notice to the public, meet in closed session, so long as the purpose of the meeting is the peer review body's discharge of its responsibility to evaluate and improve the quality of care rendered by health facilities and health practitioners, pursuant to the powers granted to the health authority. Any such peer review body and its members shall receive, to the fullest extent, all immunities, privileges, and protections available to those peer review bodies, their individual members, and persons or entities assisting in the peer review process, including those afforded by Section 1157 of the Evidence Code and Section 1370 of the Health and Safety Code.

(o) Notwithstanding any other provision of law, those records of the health authority and of the county that reveal the health authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, shall not be required to be disclosed pursuant to the California Public Records Act, Chapter 5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(p) Notwithstanding the California Public Records Act, or Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of, and Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of, the Government Code, or any other provision of state or local law requiring disclosure of public records, those records of a peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the health authority authorized by this section, shall not be required to be disclosed. The records and proceedings of any such peer review body and its individual members shall receive, to the fullest extent, all immunities, privileges, and protections available to those records and proceedings, including those afforded by Section 1157 of the Evidence Code and Section 1370 of the Health and Safety Code.

(q) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the California Public Records Act, including, but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the health authority is required to prepare, produce, or submit pursuant to this section.

(r) (1) Any health authority formed pursuant to this section shall obtain licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code).

(2) Notwithstanding subdivisions (b) and (s), a health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including tangible net equity requirements applicable to a licensed health care service plan.

(s) Commencing on the date that the health authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, the following provisions shall apply:

(1) The health authority may select and design its automated management information system, but the department, in cooperation with the health authority, prior to making capitated payments shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the health authority and any other information generally required by the department in its contracts with health care service plans.

(2) In addition to the reports required by the Department of Managed Care under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Care promulgated thereunder, the health authority shall provide on a monthly basis to the department, the Department of Managed Care, and the members of the health authority, a copy of the automated report described in paragraph (1) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets or liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association, or community clinic, that has contracted with the health authority to provide health care services.

(3) In addition to the reporting and notification obligations the health authority has under the Knox-Keene Health Care Service Plan Act of 1975, the chief executive officer or director of the health authority shall immediately notify the department, the Department of Managed Care, and the members of the governing board of the health authority in writing of any fact or facts that, in the chief

executive officer's or director's reasonable and prudent judgment, is likely to result in the health authority being unable to meet its financial obligations to health care providers or to other parties. Written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions that will be taken to address the anticipated consequences.

(4) The Department of Managed Care shall not waive or vary, nor shall the department request the Department of Managed Care to waive or vary, the tangible net equity requirements for a health authority under the Knox-Keene Health Care Service Plan Act of 1975 after three years from the date of commencement of capitated payments to the health authority. Until the time the health authority is in compliance with all of the tangible net equity requirements under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Care promulgated thereunder, the health authority shall develop a stop-loss program appropriate to the risks of the health authority. The program shall be satisfactory to both the department and the Department of Managed Care.

(5) In the event that the health authority votes to file a petition of bankruptcy, or the board of supervisors notifies the department of its intent to terminate the health authority, the department shall immediately convert the authority's Medi-Cal beneficiaries to either of the following:

(A) To other managed care contractors when available, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees.

(B) To the extent that other managed care contractors are unavailable or the department determines that the action is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or if the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another managed care system, if one is available, in full compliance with the federal freedom-of-choice requirements.

(6) The health authority shall submit to a review of financial records when the department determines, based on data reported by

the health authority or otherwise, that the health authority will not be able to meet its financial obligations to health care providers contracting with the health authority. Where the review of financial records determines that the health authority will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the director shall immediately terminate the contract between the health authority and the state, and immediately convert the health authority Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers. The action of the director shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted under paragraph (5) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(7) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a manner that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the health authority shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the health authority's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(8) In the event a health authority is terminated, files for bankruptcy, or otherwise no longer functions for the purpose for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the health authority.

(9) Nothing in this subdivision shall be construed to impair or diminish the authority of the Director of the Department of Managed Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in the section be construed to reduce or otherwise limit the obligation of a health authority licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the health commissioner of Corporations promulgated thereunder.

(t) In the event a health authority may no longer function for the purposes for which it is established, at the time the health authority's then-existing obligations have been satisfied or the health authority's assets have been exhausted, the board of supervisors may, by ordinance, terminate the health authority.

(u) (1) Prior to the termination of the health authority, the board of supervisors shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority's records within 30 days of the notification to determine the liabilities and assets of the health authority.

(2) The department shall report its findings to the board within 10 days of completion of the audit. The board shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority's assets, and present the plan to the department within 30 days upon receipt of these findings.

(v) Any assets of the health authority shall be disposed of pursuant to provisions contained in the contract entered into between the state and the health authority pursuant to this section.

(w) Upon termination of a health authority by the board, the county shall manage any remaining assets of the health authority until superseded by a department-approved plan. Any liabilities of the health authority shall not become obligations of the county upon either the termination of the health authority or the liquidation or disposition of the health authority's remaining assets.

SEC. 198. Section 14087.4 of the Welfare and Institutions Code is amended to read:

14087.4. (a) Any contract made pursuant to this article may be renewed if the provider continues to meet the requirements of this chapter, regulations promulgated pursuant thereto, and the contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may condition renewal on timely completion of a mutually agreed upon plan of correction of any deficiencies.

(b) The department may terminate or decline to renew a contract, in whole or in part, when the director determines that such action is necessary to protect the health of the beneficiaries or the funds appropriated to carry out the Medi-Cal program. Nonrenewal or termination under this article shall not qualify the applicant for an administrative hearing including a hearing pursuant to Section 14123.

(c) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this article is necessary. Therefore contracts under this article shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(d) For any contract entered into pursuant to this article, the Director of the Department of Managed Care shall, at the director's request and with all due haste, grant an exemption from the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out the contract.

SEC. 199. Section 14087.9705 of the Welfare and Institutions Code is amended to read:

14087.9705. (a) The commission shall obtain licensure as a health care service plan under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code.

(b) Commencing on the date that the commission first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and the commission is in full compliance with all of the requirements regarding tangible net equity applicable to a health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, all of the following provisions shall apply:

(1) The commission is authorized to select and design its automated management information system, subject to the requirement that the department, in cooperation with the commission, prior to making capitated payments, approve the system. The department shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the commission, and any other information that is generally required by the department in its contracts with other local initiatives and with health care service plans.

(2) In addition to the reports required by the Department of Managed Care under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code and the rules of the Director of the Department of Managed Care adopted and promulgated thereunder, the commission shall provide, on a monthly basis, to the department, the Department of Managed Care, and the members of the commission a copy of the automated report described in subdivision (a) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets and liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association, or community clinic that has contracted with the commission to provide health care services.

(3) In addition to the reporting and notification requirements to which the commission is subject under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, the chief executive officer or director of the commission shall immediately notify the department, the Department of Managed Care, and the members of the commission, in writing, of any fact or facts that, in the chief executive officer's or director's reasonable and prudent judgment, is likely to result in the commission being unable to meet its financial obligations. The written notice shall describe the

fact or facts, the anticipated financial consequences, and the actions that will be taken to address the anticipated consequences.

(4) In no event shall the Department of Managed Care waive or vary, nor shall the department request the Department of Managed Care to waive or vary, the tangible net equity requirements for a commission under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code after three years after the date of the commencement of capitated payments to the commission. Until the commission is in compliance with all of the tangible net equity requirements under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code and the rules of the Director of the Department of Managed Care adopted and promulgated thereunder, the commission shall develop a stop-loss program that is appropriate to the risks of the commission. The stop-loss program shall be subject to the approval of the department and the Department of Managed Care.

(5) In the event the commission votes to file a petition of bankruptcy, or the board of supervisors notifies the department that it intends to terminate the commission, the department shall immediately transfer the commission's Medi-Cal beneficiaries to other managed care contractors, when the contractors are available, and the contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees. To the extent that other managed care providers are unavailable or the department determines that the transfer to the other contractors to a fee-for-service reimbursement system is in the best interest of any particular beneficiary, the department shall make that transfer to the fee-for-service system, pending the availability of managed care contractors that can demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or until the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary. Beneficiaries who have been or who are scheduled to be transferred to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another managed care system, if one is available, in full compliance with federal freedom-of-choice requirements.

(6) The commission shall submit to a review of financial records when the department determines, based on data reported by the commission or other data received by the department, that the commission will not be able to meet its financial obligations to health care providers contracting with the commission. If the department, pursuant to a review of financial records under this paragraph, determines that the commission will not be able to meet its financial

obligation to contracting health care providers for the provision of health care services, the Director of Health Services shall immediately terminate the contract between the commission and the department and shall immediately transfer the commission's Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to beneficiaries and to minimize financial disruption. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be transferred under paragraph (5) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(7) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a manner that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the commission shall authorize the department to administer the number of covered Medi-Cal enrollments in a manner that ensures that the commission's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(8) In the event a commission is terminated, files for bankruptcy, or otherwise no longer functions for the purposes for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the commission.

(9) Nothing in this section shall be construed to impair or diminish the authority of the Director of the Department of Managed Care under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, nor shall any thing in this section be construed to reduce or otherwise limit the obligation of a commission licensed as a health care plan under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code to comply with the requirements of that chapter, and the rules of the Director of the Department of Managed Care adopted thereunder.

SEC. 200. Section 14088.19 of the Welfare and Institutions Code is amended to read:

14088.19. (a) The department may enter into primary care case management contracts pursuant to this article with any health care service plan that is licensed by the Director of the Department of Managed Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

The terms of the contracts entered into pursuant to this section shall be exempt from those provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that regulate health care service plan contracts. Nothing in this section shall preclude the Director of the Department of Managed Care from otherwise regulating a health care service plan subject to the Knox-Keene Health Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(b) When a health care service plan enters into a contract pursuant to this article and also pursuant to Chapter 8 (commencing with Section 14200), there shall be no duplication of service areas between the two contracts without prior written approval by the department.

SEC. 201. Section 14089 of the Welfare and Institutions Code is amended to read:

14089. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is, further, the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed case arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.

(b) The negotiator may seek proposals and then shall contract based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:

(1) Certification, where legally required, by the Director of the Department of Managed Care and the Insurance Commissioner.

(2) Compliance with all of the following:

(A) The health plan shall satisfy all applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.

(B) The health plan shall meet any standards established by the department for the implementation of this article.

(C) The health plan receives the approval of the department to participate in the pilot project under this article.

(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid or postpayment basis.

(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(2) The cost of each program established under this section shall not exceed the total amount which the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(d) The department shall enter into contracts pursuant to this article, and shall be bound by the rates, terms, and conditions negotiated by the negotiator.

(e) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. Enrollment shall be for a minimum of six months. Contracts entered into pursuant to this article shall be for at least one but no more than three years. The director shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides.

(2) No later than 30 days following the date a Medi-Cal or AFDC recipient is informed of the health care options described in paragraph (1) of subdivision (e), the recipient shall indicate his or her choice in writing of one of the available health care plans and his or her choice of primary care provider or clinic contracting with the selected health care plan.

(3) The health care options information described in paragraph (1) of subdivision (e) shall include the following elements:

(A) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, and each clinic participating in each health care plan. This information shall be presented under geographic area designations in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each health care plan shall be made available by contacting the health care options contractor or the health care plan.

(B) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the health

plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.

(C) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a health care plan.

(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected health care plan.

(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or AFDC beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in an appropriate health care plan providing service within the area in which the beneficiary resides.

(6) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the health care plan selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(7) Any Medi-Cal or AFDC beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.

(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.

(9) This section shall be implemented in a manner consistent with any federal waiver that is required to be obtained by the department to implement this section.

(f) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government, and others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.

(g) The negotiator and the department shall establish pilot projects to test the cost-effectiveness of delivering benefits as defined in subdivisions (a) to (f), inclusive.

(h) The California Medical Assistance Commission shall evaluate the cost-effectiveness of these pilot projects after one year of implementation. Pursuant to this evaluation the commission may either terminate or retain the existing pilot projects.

(i) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.

(j) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

SEC. 202. Section 14089.4 of the Welfare and Institutions Code is amended to read:

14089.4. The negotiator may consult with the Department of Insurance or the Department of Managed Care and shall consult with the Department of Justice Medi-Cal Fraud Unit, the appropriate licensing boards and the laboratory field services unit of the department for the purposes of determining the qualifications, performance capability, and financial stability of prospective contractors.

SEC. 203. Section 14139.13 of the Welfare and Institutions Code is amended to read:

14139.13. (a) Any contract entered into pursuant to this article may be renewed if the long-term care services agency continues to meet the requirements of this article and the contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may condition renewal on timely completion of a mutually agreed upon plan of corrections of any deficiencies.

(b) The department may terminate or decline to renew a contract in whole or in part when the director determines that the action is necessary to protect the health of the beneficiaries or the funds appropriated to the Medi-Cal program. The administrative hearing requirements of Section 14123 do not apply to the nonrenewal or termination of a contract under this article.

(c) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this article is necessary. Therefore, contracts under this article shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(d) The Director of the Department of Managed Care shall, at the director’s request, immediately grant an exemption from Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and

Safety Code for purposes of carrying out any contract entered into pursuant to this article.

SEC. 204. Section 14251 of the Welfare and Institutions Code is amended to read:

14251. ''Prepaid health plan'' means any plan which meets all of the following criteria:

(a) Licensed as a health care service plan by the Director of the Department of Managed Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340), Division 2, Health and Safety Code), other than a plan organized and operating pursuant to Section 10810 of the Corporations Code which substantially indemnifies subscribers or enrollees for the cost of provided services, or has an application for licensure pending and was registered under the Knox-Mills Health Plan Act prior to its repeal (Chapter 941, Statutes of 1975) or licensed as a nonprofit hospital service plan by the Insurance Commissioner pursuant to Section 11493(e) and Sections 11501 to 11505 of the Insurance Code.

(b) Meets the requirements for participation in the Medicaid Program (Title XIX of the Social Security Act) on an at risk basis.

(c) Agrees with the State Department of Health Services to furnish directly or indirectly health services to Medi-Cal beneficiaries on a predetermined periodic rate basis.

''Prepaid health plan'' includes any organization which is licensed as a plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 and is subject to regulation by the Department of Managed Care pursuant to that act, and which contracts with the State Department of Health Services solely as a fiscal intermediary at risk.

Except for the requirement of licensure pursuant to the Knox-Keene Act, the State Director of Health Services may waive any provision of this chapter which the director determines is inappropriate for a fiscal intermediary at risk. Any such exemption or waiver shall be set forth in the fiscal intermediary at risk contract with the State Department of Health Services.

''Fiscal intermediary at risk'' means any entity which entered into a contract with the State Department of Health Services on a pilot basis pursuant to subdivision (f) of Section 14000, as in effect June 1, 1973, in accordance with which the entity received capitated payments from the state and reimbursed providers of health care services on a fee-for-service or other basis for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk shall be at risk for the cost of administration and utilization of services or the cost of services, or both, for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic

region of the state. The fiscal intermediary at risk may share the risk with providers or reinsuring agencies or both. Eligibility of beneficiaries shall be determined by the State Department of Health Services and capitation payments shall be based on the number of beneficiaries so determined.

SEC. 205. Section 14308 of the Welfare and Institutions Code is amended to read:

14308. (a) Each prepaid health plan shall furnish to the director such information and reports as required by Title XIX of the federal Social Security Act.

(b) The director may require a prepaid health plan to provide the director with information and reports which are furnished by the prepaid health plan to the Director of the Department of Managed Care pursuant to the provisions of Chapter 2.2 (commencing with Section 1340), Division 2, of the Health and Safety Code, the Knox-Keene Health Care Service Plan Act of 1975, or to the Insurance Commissioner pursuant to the provisions of Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate.

(c) The director may, by regulation, require plans to furnish statistical information to the extent such information is necessary for the department to establish rates of payment pursuant to Section 14301 and to provide reports pursuant to Section 14313. The department shall, to the extent feasible, accept this information in a form which is consistent with reports required to be provided pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate. In the case of a hospital based plan which is a health maintenance organization qualified pursuant to Title XIII of the federal Public Health Service Act, and which has more than one million enrollees, of whom less than 10 percent are Medi-Cal enrollees, information required pursuant to this subdivision shall consist of reports required to be made to the Department of Health, Education and Welfare pursuant to Title XIII of the federal Public Health Service Act.

SEC. 206. Section 14456 of the Welfare and Institutions Code is amended to read:

14456. The department shall conduct annual medical audits of each prepaid health plan unless the director determines there is good cause for additional reviews.

The reviews shall use the standards and criteria established pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate. Except in those instances where major unanticipated administrative obstacles prevent, or after a determination by the director of good cause, the reviews shall be scheduled and carried out jointly with reviews

carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate, if reviews under either act will be carried out within time periods which satisfy the requirements of federal law.

The department shall be authorized to contract with professional organizations or the Department of Managed Care or the Department of Insurance, as appropriate, to perform the periodic review required by this section. The department, or its designee, shall make a finding of fact with respect to the ability of the prepaid health plan to provide quality health care services, effectiveness of peer review, and utilization control mechanisms, and the overall performance of the prepaid health plan in providing health care benefits to its enrollees.

SEC. 207. Section 14457 of the Welfare and Institutions Code is amended to read:

14457. In addition to the reviews required or authorized by Section 14456, the department shall conduct periodic onsite visits or additional visits after a determination by the director of good cause by departmental representatives to include observation of the general operation of the prepaid health plan, the condition of the facilities for delivering health care, the availability of emergency services, the degree of satisfaction of the enrollees, the operation of the plan's grievance system, and the administrative and financial aspects of the operation of the prepaid health plan.

Except when reviewing a plan's grievance system or marketing activities, this evaluation shall use standards and criteria established pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate. Except in those instances where major, unanticipated administrative obstacles prevent, or after a determination by the director of good cause, the visits shall be scheduled and carried out jointly with reviews carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate, if reviews under either act will be carried out within time periods which satisfy the requirements of federal law.

The State Department of Health Services may contract with the Department of Managed Care or the Department of Insurance, as appropriate, to perform the periodic visits required by this section.

SEC. 208. Section 14459 of the Welfare and Institutions Code is amended to read:

14459. (a) The prepaid health plan shall maintain financial records and shall have an annual audit or additional audits after a determination by the director of good cause, performed by an independent certified public accountant. A prepaid health plan

operated by a public entity shall have an annual audit performed in a manner approved by the department. All certified financial statements shall be filed with the department as soon as practical after the end of the prepaid health plan's fiscal year and in any event, within a period not to exceed 90 days thereafter. These financial statements shall be filed with the department and shall be public records. The department shall perform routine auditing of prepaid health plan contractors and their affiliated subcontractors. Except in those instances where major unanticipated obstacles prevent, or after a determination by the director of good cause, the audits shall be scheduled and carried out jointly with audits carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate, if audits under either act are carried out within time periods which satisfy the requirements of federal law. The department is authorized to contract with the Department of Managed Care or the Department of Insurance, as appropriate, to carry out the audits required by this section. The prepaid health plan shall make all of its books and records available for inspection, examination or copying by the department during normal working hours at the prepaid health plan's principal place of business or at such other place in California as the department shall designate. For good cause, the department may grant an exception to the time when annual financial statements are to be submitted to the department. The annual report required in Section 14313 shall include an itemization of expenditures made by each prepaid health plan for the following categories of expenditures: physician services, inpatient and outpatient hospital services, pharmaceutical services and prescription drugs, dental services, medical transportation services, vision care services, mental health services, laboratory services, X-ray services, enrollee education programs, marketing and enrollment costs, data-processing costs, other administrative costs and health service expenditures and any payments made to subcontractors, and the purposes of the payments, including but not limited to, contributions to election campaigns.

(b) The requirements of a financial and administrative review by the department of any health care service plan licensed by the Director of the Department of Managed Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code may be waived upon submission of the financial audit for the same period conducted by the Department of Managed Care pursuant to Section 1382 of the Health and Safety Code.

SEC. 209. Section 14460 of the Welfare and Institutions Code is amended to read:

14460. A schedule of reviews, visits, and audits shall be jointly established by the Department of Managed Care or the Department of Insurance, as the case may be, and the State Department of Health

Services. Nothing in Section 14456, 14457, or 14459 shall be construed to prohibit the State Department of Health Services from conducting reviews, visits, or audits either jointly or individually, for the purpose of following up on findings resulting from reviews, visits, or audits carried out in accordance with this chapter.

SEC. 210. Section 14482 of the Welfare and Institutions Code is amended to read:

14482. No prepaid health plan shall contract with any subcontractor other than the plan's subsidiary corporation, its parent corporation, or another subsidiary of its parent corporation, or an affiliate of the prepaid health plan whose financial statements are consolidated with that of the prepaid health plan at the time of the annual audit by the independent auditors of the plan and when the quarterly and annual financial statements are filed with the Director of the Department of Managed Care, if any of the following persons connected with the plan have a substantial financial interest, as defined by Section 14478, in such subcontractor:

(a) Any person also having a substantial financial interest in the plan.

(b) Any director, officer, partner, trustee, or employee of the plan.

(c) Any member of the immediate family of any person designated in (a) or (b).

SEC. 211. Section 14499.71 of the Welfare and Institutions Code is amended to read:

14499.71. For the purposes of this article, ''fiscal intermediary'' means an entity that agrees to pay for covered services provided to Medi-Cal eligibles in exchange for a premium, subscription charge, or capitation payment; to assume an underwriting risk; and is either licensed by the Director of the Department of Managed Care under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or is licensed as a nonprofit hospital service plan by the Insurance Commissioner pursuant to subdivision (e) of Section 11493 of the Insurance Code and Sections 11501 to 11505, inclusive, of the Insurance Code.

SEC. 212. Section 22005 of the Welfare and Institutions Code is amended to read:

22005. The department shall only certify long-term care insurance policies and health care service plan contracts which cover long-term care that provide all of the following:

(a) Individual case management by a coordinating entity designated or approved by the department.

(b) The levels and durations of benefits which meet minimum standards set by the department.

(c) Protection against loss of benefits due to inflation.

(d) A recordkeeping system including an explanation of benefit report on insurance payments or benefits which count toward Medi-Cal resource exclusion.

(e) Approval of the insurance policy by the Department of Insurance as meeting the requirements of Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code, excepting the requirements of Sections 10232.1, 10232.2, 10232.25, 10232.8, 10232.9, and 10232.92, or approval of the health care service plan contract by the Department of Managed Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code as providing substantially equivalent coverage to that required by Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code.

(f) Compliance with any other requirements imposed by the department through regulations consistent with the purposes of this division.

SEC. 213. Section 22010 of the Welfare and Institutions Code is amended to read:

22010. An executive and legislative advisory task force shall be formed to provide advice and assistance in designing and implementing the California Partnership for Long-Term Care Pilot Program.

(a) The task force shall be composed of representatives, designated by the chief officer or director of their agency or department, of:

(1) The State Department of Health Services.

(2) The State Department of Social Services.

(3) The Department of Aging.

(4) The Department of Insurance.

(5) The Department of Managed Care.

(6) The Senate Office of Research.

(7) The Assembly Office of Research.

(b) The task force shall consult with persons knowledgeable of and concerned with long-term care, including, but not limited to:

(1) Consumers.

(2) Health care providers.

(3) Representatives of long-term care insurance companies and administrators of health care service plans which cover long-term care services.

(4) Providers of long-term care.

(5) Private employers.

(6) Academic specialists in long-term care and aging.

(7) Representatives of the public employees' and teachers' retirement systems.

SEC. 214. This act shall become effective on January 1, 2000, and shall become operative on the date that the Governor, by executive

order, establishes the Department of Managed Care or July 1, 2000, whichever occurs first.

SEC. 215. (a) Subject to subdivision (b), any section of any act enacted by the Legislature during the 1999 calendar year that takes effect on or before January 1, 2000, and that amends, amends and renumbers, adds, repeals and adds, or repeals a section that is amended, amended and renumbered, repealed and added, or repealed by this act, shall prevail over this act, whether that act is enacted prior to, or subsequent to, the enactment of this act.

(b) Subdivision (a) shall not apply to any of the following provisions of this act:

(1) Every provision of this act that amends any section of, adds any section to, or repeals and adds any section of, the Health and Safety Code.

(2) Sections 1618.5 and 4382 of the Business and Professions Code, as amended by this act.

(3) Sections 43.98, 56.17, and 3296 of the Civil Code, as amended by this act.

(4) Sections 10821 and 13408.5 of the Corporations Code, as amended by this act.

(5) Sections 1322, 6253.4, 6254.5, 11552, 13975, 21661, 31696.1, 37615.1 of the Government Code, as amended by this act, and Section 13975.2 of the Government Code, as added by this act.

(6) Sections 740, 742.407, 1068, 1068.1, and 10856 of the Insurance Code, as amended by this act.

(7) Section 830.3 of the Penal Code, as amended by this act.

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